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ABSTRACT

This document, the result of the collaborative efforts of the members of the Prime Study Group of the Institute on Rehabilitation Issues, provides information concerning techniques, strategies, models, and resources for rehabilitation professionals who are working with persons with coexisting abuse problems and disabling conditions. Chapter I, an introduction, defines "coexisting disability," outlines prevalence and incidence, examines multicultural issues, and explores personal and social attitudes about substance abuse. Chapter II addresses the medical aspects of substance abuse, covering the classification of substances; effects on the central nervous system; pharmacology; and interaction of substances with physical, cognitive, mental, and emotional disabilities. Chapter III considers assessment of substance abuse as a coexisting disability, with special attention given to the diagnostic interview. It describes signs and symptoms of substance abuse, criteria for psychoactive substance dependency, and methods of detecting substance abuse. Chapter IV covers the definition of treatment, intervention strategies, the need for family involvement, and interagency cooperation. Chapter V begins with the vocational rehabilitation counselor's responses to substance abusing clients and then addresses resources and networking, confidentiality, and appropriate methods for sharing information. Chapter VI discusses how traditional substance abuse treatment programs fail to meet the needs of many persons with disabilities and discusses ways to develop more accessible treatment programs. Chapter VII addresses job development and placement in cases of substance abuse as a coexisting disability. Appendices contain the 12-step model for addiction recovery, a glossary of drug street language, and an annotated list of 19 suggested readings. (Each chapter contains references.) (JDD)

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EIGHTEENTH INSTITUTE ON REHABILITATION ISSUES

SUBSTANCE ABUSE AS A COEXISTING DISABILITY

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Report from the Study Group on

SUBSTANCE ABUSE AS A COEXISTING DISABILITY

David W. Corthell, Ed.D.
Editor and IRI University
Coordinator

James Brown, Ph.D.
Chairperson
Prime Study Group

RESEARCH AND TRAINING CENTER
Stout Vocational Rehabilitation Institute
University of Wisconsin-Stout
Menomonie, Wisconsin 54751

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Prime Study Group

Eighteenth Institute on Rehabilitation Issues

Sponsor: University of Wisconsin-Stout, Research and Training Center

Pete Anderson
Director
Congress on Chemical Dependency
and Disability
AODA Department of Human Services
15519 Crenshaw Boulevard, Suite 209
Gardina, CA 90249

Karl Botterbusch, Ph.D., CVE
Research Specialist, Professor
Research and Training Center
University of Wisconsin-Stout
Menomonie, WI 54751

James Brown, Ph.D., Chairperson
VR state Psychological Consultant
Florida Department of Labor and
Employment Security
Division of Vocational Rehabilitation
1709-A Mahan Drive
Tallahassee, FL 32399-0696

David Burganowski
Associate Director
Region II RCEP
State University of NY at Buffalo
441 Christopher Baldy Hall
Buffalo, NY 14260

David W. Corthell, Ed.D.
Director of Training and
University Sponsor
Research and Training Center
University of Wisconsin-Stout
Menomonie, WI 54751

J. A. Durate
Program Specialist
Texas Rehabilitation Commission
Central Office
4900 North Lamar Boulevard
Austin, TX 78751-2316

Bobby G. Greer
Professor
Department of Counseling and
Personnel Services
Ball Hall #102
Memphis State University
Memphis, TN 38152

Sandy Ingram
Substance Abuse Specialist
North Carolina Department of
Human Resources
Division of Vocational Rehabilitation
Services
620 North West Street, P.O. Box 26053
Raleigh, NC 27611

Robert Stevens
VR Project Supervisor
Palmetto Center
P.O. Box 5357
Florence SC 29502

E. W. (Bud) Stude, E.D.
Professor/Coordinator
California State University-Fresno
Rehabilitation Counseling Program
Shaw and Cedar Avenue
Fresno, CA 93740

Rhodora Tumanon, MD
Medical Director
Maryland Rehabilitation Center
2301 Aroganne Drive
Baltimore, MD 21218

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David Burganowski, Region II RCEP, has had the lead in developing training materials in the area of substance abuse and coexisting disability. He brought his broad knowledge of the substance abuse literature and trainer skills to the Prime Study Group and had a major role in the development of the first chapter. E. W. Stude, Professor/Coordinator, Rehabilitation Counseling Program, added his knowledge of preservice training needs. In addition, he contributed his knowledge of the medical aspect of substance abuse along with Rhodora Tumanon, M.D. Pete Anderson is the Director of the Congress on Chemical Dependency and Disability, an AODA counselor, and has extensive knowledge on treatment and accommodations techniques for many individuals with other disabilities. His input is seen throughout the book, particularly its sensitivity to consumer needs and issues.

Several members of the Prime Study Group strengthen the vocational rehabilitation counselor perspective. These persons included: Robert Stevens, Vocational Rehabilitation Supervisor; J. A. Durate, Program Specialist; and Sandy Ingram, DVR Substance Abuse Specialist. Each wrote a significant portion of chapters dealing with practical application of vocational rehabilitation procedure in serving persons with substance abuse problems in association with other disabilities. Ingram and Stevens also served on the editorial committee, while Durate will serve as a Chairperson of an IRI Prime Study Group in 1992.

Professor Bobby Greer has published extensively in this field. He brought his extensive knowledge and wit to the work of the Prime Study Group. Karl Botterbusch brought the group information about several treatment methodologies and models. He took responsibility for incorporating input from several individuals in the development of the treatment chapter.

James Brown, Vocational Rehabilitation State Psychological Consultant, performed triple duty. He served as Chairperson of the Prime Study Group and contributed his knowledge of assessment and multicultural issues. In addition, he served on the editorial committee which incorporated concerns of the persons attending the annual meeting.

Staff of the Resource Center on Substance Abuse Prevention and Disability contributed the content of Appendix C. The reader will find the annotated bibliography an excellent resource for further readings on this subject.

The contributions of those individuals who attended the annual meeting and critiqued the materials developed by the prime writing group are acknowledged. Their cogent comments were

taken to heart by the editorial committee and incorporated into the final text.

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David W. Corthell, Ed.D., Editor
and IRI University Sponsor

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Preface

In their collective wisdom, rehabilitation counselors have recognized that a significant portion of the persons whom they serve have two or more disabilities. The first disability, the reason they were referred, was often recognized as a physical or mental disability. It is usually easily diagnosed with common functional limitations. The second disability, substance abuse, is rarely mentioned and often recognized late in the rehabilitation process. The disruption caused by a second recognized disability or coexisting disability of substance abuse is known by rehabilitation practitioners on a case-by-case basis. However, frequently the dimensions of the problem are overlooked. When asked if they "drink a lot," the clients may indicate having had a few beers last night but usually don't get drunk: "Well, sometimes when I'm out with friends on the weekend and need a ride home--you know, like everyone else."

Informally, the senior editor asked seven substance abuse counselors in rehabilitation to estimate the percent of a general rehabilitation caseload who they felt, also abused alcohol or other drugs. The estimates ranged from 25% with a known problem to 75% if those with a significant problem were counted. Even at the low end, this would cause significant cause for alarm. One can only guess the true percent of persons served by the state rehabilitation agency that have a coexisting substance abuse problem. The hallmark of this disability is denial. Substance abusers are very creative in disguising the misuse of chemicals. Consequently, the true dimensions of the problem may never be known.

Brief Overview of the Chapters

In Chapter I, a discussion of the importance of this topic is provided along with a definition of "Coexisting Disability." It expands on some fundamental information on the prevalence and incidence of at risk disability groups, the importance of understanding the multi-cultural issues around substance abuse, the experience of the addiction process, and the exploration of personal and social attitudes about substance abuse.

Chapter II addresses the medical aspects of substance abuse. It covers the classification of substances; the major effects of substances on the central nervous system; pharmacology of a myriad of substances; and the interaction of substances with physical, cognitive, mental, and emotional disabilities.

Chapter III describes the process of assessment of substance abuse as a coexisting disability, with special attention given to the diagnostic interview. It will describe the sign and symptoms of substance abuse, list indicators of this disorder, give the criteria for psychoactive substance dependency, discuss the interaction of substance abuse and disabilities, list methods of detecting substance abuse, and define dual diagnosis treatment.

The process of treatment is addressed in Chapter IV. It covers a broad range of topics from the definition of treatment to intervention strategies. In addition to treatment approaches and techniques, the need for family involvement and interagency cooperation are discussed.

Chapter V begins with the vocational rehabilitation counselor's responses to substance abusing clients and then moves into resource and networking information. It discusses confidentiality and appropriate methods for sharing information.

Chapter VI discusses the ways traditional substance abuse treatment programs are not appropriate for many persons with disabilities. It will provide a discussion of components that could be used to improve or develop a more accessible substance abuse treatment program for individuals with disabilities. The need for disability awareness training for AODA counselors is also discussed.

Chapter VI addresses the special considerations in job development and placement where substance abuse is a coexisting disability. In addition to discussions on job development and placement, it includes discussions on establishing an aftercare program, employer attitudes about substance abuse treatment, and the relapse phenomenon.

Purpose of the Document

This document is intended to provide information concerning techniques, strategies, models, and resources for rehabilitation professionals who are working with persons with substance abuse and disabling conditions. It was developed in response to an expressed need of service providers for a method to meet the vocational rehabilitation counseling needs of persons with this coexisting disability. Its main function is to assist rehabilitation counselors to understand and use new techniques along with the more traditional rehabilitation strategies to improve the lives of persons with disabilities.

Audience

This document is designed for a wide variety of rehabilitation practitioners. This can include rehabilitation administrators, rehabilitation counselors, rehabilitation facilities staff, independent living center staff, and client assistant personnel.

Chapter I

INTRODUCTION

This training document will address several issues regarding substance abuse as a coexisting disability. Among the issues discussed are the following:

- Why are persons with disabilities more vulnerable to substance abuse and addiction? Are there special sub-populations of persons with disabilities with higher rates of substance abuse?

- What are some of the indicators of substance abuse and what should be done after signs of a substance abuse problem are found?

- What impact does the counselor's attitude about substance abuse and dependency have on the quality of services provided?

- Why are most traditional substance abuse treatment programs inappropriate for persons with disabilities?

- What does a rehabilitation counselor need to know about job development, placement, and follow up when it comes to clients with substance abuse and disabilities?

- The applicant was addicted to alcohol and/or drugs but is now in remission. Is the person eligible for vocational rehabilitation services?

- Do vocational rehabilitation counselors know enough about substance abuse as a coexisting disability to provide quality vocational rehabilitation services?

These questions are just a few of the more interesting issues professionals meet when working with persons with disabilities who also have substance abuse as a coexisting disability. This document will attempt to provide you with the information necessary to address these and other common questions and concerns.

RELEVANCE TO VOCATIONAL REHABILITATION

Why study substance abuse as it relates to people with disabilities? Must counselors become scholars in the area of substance abuse/use in order to become accomplished rehabilitation professionals? Is it really that important?

The answer to the latter question is an emphatic yes! The study of substance abuse and disabilities will help us better serve more consumers in an effective and judicious manner than

otherwise would be possible. A basic knowledge of the relationship between substance abuse/use and various other disabilities will allow us to provide the much needed services. Often substance abuse is ignored, and the mistake is made of focusing on the other disability as the primary problem. How deeply one delves into the topic is, of course, a personal choice. Some will become engrossed in this area and may become specialists in their offices or agencies. Others will desire only the fundamentals, which will at least allow them to assess and refer at the appropriate time in the rehabilitation process. Recognizing the problem and making a proper referral means appropriate rehabilitation services are provided.

A certain minimum knowledge is essential to providing new insights into understanding and treating the problems of persons with coexisting disabilities. The study need not be too involved, but certain elementary facts must be learned. Without this knowledge, the counselor will continue to be ill-equipped for the process of rehabilitating persons with disabilities.

In recent years the prevalence of substance use and abuse in society has reached unprecedented proportions. It is an area widely researched and discussed in both the popular and professional media. Much literature has been published identifying the need for special consideration to be given to the diagnosis, treatment, prevention, and aftercare of substance abusers. However, little or no attention has been given to the needs of individuals who are disabled and also abusing substances. Rehabilitation professionals are currently recognizing and exploring the growing evidence that people with disabilities seem particularly vulnerable to substance abuse and dependence. This attention has not yet been extended to include the specific concerns of all disability groups.

According to Frederick Sachs, formerly of the Rehabilitation Services Administration, the rehabilitation counselor is in an opportune position to assist in the identification of persons impaired by substance abuse. However, rehabilitation counselors who have not worked with substance abuse clients may not recognize the signs and symptoms in a client's appearance, behavior, or history. Persons with disabilities and concurrent substance abuse problems compound the issue, presenting both classic and unique concerns.

Tendencies to assess and address only the "primary" or presenting disability can mask and consequently enable continued substance abuse. Continued substance abuse threatens the physical well being of a person with a disability. As important is the fact that it undermines the entire rehabilitation process and interferes with progress toward vocational placement and independent living.

DEFINITION OF COEXISTING DISABILITY

The 1980-1981 issue of Alcohol Health & Research World used the term "multi-disabled alcoholic," referring to an alcoholic who had the additional disability of a mental or physical impairment. Evans and Sullivan in a recent book titled Dual Diagnosis Counseling: The Mentally Ill Substance Abuser (1990), use the term "dual diagnosis" to refer to an individual with both a substance abuse or dependency problem and a coexisting psychiatric disorder. The June 1982, Vol. 5, Number 6 issue of the Rehab Brief used the term "secondary disability" referring to alcoholism as one which can sabotage apparently well-laid rehabilitation plans. The

1991 Prime Study Group Members on substance abuse and disabilities uses the term "coexisting disability" or "hidden disability," referring to a person who has one or more physical, mental,or cognitive disabling condition in combination with a substance abuse/dependency problem. Our definition has been broadened to include other substances in addition to alcohol. Research indicates most people who could be considered abusers do so with a variety of substances, leading to coining the term "polysubstance abuser."

It is clear to many in the rehabilitation field that among persons receiving rehabilitation services for physical or mental disabling conditions, an additional disabling condition often goes undetected, ignored, untreated, and undocumented: they also have a substance abuse problem. Substance abuse can be a problem with any disability, e.g., traumatic brain injury, psychiatric disorders, visual impairment, blindness, spinal cord injuries, hearing impairments, learning disabilities, and developmental disabilities. The substance abuse can occur prior to treatment, during the treatment process, or after release from medical treatment.

There seems to be a reluctance among professionals to acknowledge the existence of substance abuse as a disability for persons who have a physical or mental disability. The literature indicates a number of reasons that can account for this phenomenon:

- Professionals may be overly concerned about adding another label (substance abuser or alcoholic) to a population that has already been stigmatized.
- There is a lack of training and knowledge among vocational rehabilitation and substance abuse professionals about each other's field.
- There may be resistance on the part of the professional to acknowledge the existence of yet another disabling condition for them to deal with.
- There may be a tendency to "understand" the substance abuse as a reaction to the pain of disability.

What does this client or consumer who has a disability and who also abuses chemicals look like?

> Carlo is a 33-year-old man who has cerebral palsy and is hearing-impaired. He usually uses a wheelchair for mobility. His speech is slow and difficult to understand. Carlo's body movements are spastic, frequently involuntary. He has constant facial grimaces which make it difficult to interpret facial expressions; and the constant movement of his head makes eye-contact difficult. Carlo is currently hospitalized following admission for Valium and Methadone overdose.
>
> Carlo states that Valium was originally prescribed 18 years ago by his dad's physician without seeing Carlo. Prior to his admission for chemical dependency treatment three years ago, he was using approximately 150 mg. of Valium per day. He left treatment against medical advice. Carlo has been restricted to one physician and one pharmacy because of his drug use. Prior to this hospital admission, he was using approximately 80 mg. of Valium daily (40 mg. which

was prescribed by another physician who Carlo was seeing on a private-pay basis). Carlo has developed an increased tolerance to Valium and has experienced withdrawal symptoms when he has attempted to discontinue the drug. Carlo had also been taking Methadone for the past four weeks for back pain. The patient's social worker states that Carlo has had 20 hospital contacts over the last seven months, 13 of which were emergency room visits to procure drugs from other physicians. During this period of time Carlo has reportedly used Demerol, Vistaril, Morphine, and Dilaudid in addition to Valium and Methadone. According to the social worker, Carlo uses alcohol occasionally, drinking alone and gulping drinks on those occasions.

The patient indicates he had a Valium overdose eleven years ago and multiple intentional suicide attempts at ages 21-22. He has had two chemical-related gunshot wounds and reportedly keeps a loaded pistol at home. He currently acknowledges blackouts. The patient seems to be poorly adjusted to his disability--denying his limitations, using the spasticity and pain to justify his drug use and not utilizing his capabilities. Carlo has not been working or in school. The patient states he is isolated from his family which he attributes to his mother's alcoholism.

The social worker states he is prepared to institute commitment proceedings if Carlo does not voluntarily enter treatment.

Of course Carlo's case is unique, but it does illustrate several characteristics which are frequently observed when substance abuse is present with another disability. Carlo is abusing legal drugs, which he started on and has continued to obtain through legal prescriptions, which he has learned to obtain by using a medical system ignorant of the danger signs of substance abuse. His original use of drugs may have been for relief of pain or other symptoms of his disability, but his current and continued use is driven by addiction. He has abused may substances. His abuse has caused many problems, which may not be recognized as being related to his substance abuse. It is certain that his problems will not be resolved nor his vocational rehabilitation successful until his substance abuse is recognized and treated.

HISTORY/PREVALENCE AND INCIDENCE OF AT RISK DISABILITY GROUPS

Due to the limiting availability of literature on substance abuse and persons with disabilities, it is difficult to draw definitive conclusions regarding the nature and effects substance abuse has on the disabled individual. Research has been perplexing in this area for a variety of reasons: definitions of use, misuse and abuse vary from study to study, and group demographics vary.

Persons with disabilities are one of the largest minority populations in the nation. While there are multiple sources of data that estimate the size of the population, the National Health Interview Survey (NHIS) and the Survey of Income and Program Participation (SIPP) estimate that approximately thirty-two million (13.5%) of the 238.5 million persons in the United States

outside institutions have some disabling condition. This condition is a long-term reduction in activity resulting from a chronic disease or impairment. Kraus and Stoddard (1989) reported, according to the Census Bureau, 20% of the non-institutionalized persons age 15 and over are limited in their ability to perform selected physical functions (37.3 million persons). In her article Rehabilitation Defined, Commissioner Nell C. Carney of the Rehabilitation Services Administration indicates that there are approximately 43 million Americans who have a physical and/or mental disability, the majority of which do not require lifelong care (National Rehabilitation Association Newsletter, March, 1991).

When the aging of our population and the remarkable medical advances being made are taken into account, it becomes clear that this portion of our population will substantially increase over the years.

> Before the day is over, more than 260 people will die either because they themselves were under the influence of alcohol (substance) or because they fell victim to someone who was.
>
> Before the day is over, how many people will become disabled or dependent because they themselves fell victim to (substance abuse or dependency) or because they fell victim to someone who was?
>
> (NIAAA, Alcohol and Health, 1989).

According to the National Clearinghouse for Alcohol & Drug Information (1987), there are nearly 10.5 million alcoholics in the United States and an additional 7 million who are considered to be "alcoholic abusers." (An alcoholic is defined as someone who has developed a physiological dependency on alcohol.) A 1985 survey by the National Institute on Drug Abuse (NIDA) showed that 23 million people in this country used illicit drugs, not including alcohol, within the past month. This figure alone represents nearly 10% of our total population. The National Institute on Drug Abuse (1985) indicated that alcohol use among adults is near epidemic proportions. The Department of Health and Human Services has stated that the third most significant health problem in the United States is alcoholism and that it is the leading cause of complications in other disabling conditions.

Substance abuse is again grabbing public attention. It is now re-emerging in the field of rehabilitation and is seen by vocational rehabilitation professionals as a serious and potentially dangerous threat to persons with disabilities. Physicians, psychologists, therapists, nurses, and rehabilitation counselors are once again taking a hard look at the impact that chemical addiction can have on the physical and vocational rehabilitation of people recovering from traumatic injury.

There is a growing awareness among the rehabilitation community of the need to assist individuals with both sets of disabilities. Persons with both a physical or mental disabling condition and a substance abuse/dependency disability are increasing in number. Both conditions interact exponentially, compounding the persons' distress and disability. Making accurate and appropriate treatment decisions can be very difficult. As we know, the cardinal feature of substance abuse/dependency is denial. These individuals often manifest and exhibit dual denial.

One form of the denial is centered around their presenting disability while the other is centered around their substance abuse. This dual denial makes them extremely resistant to treatment and makes the conventional treatment approaches less effective.

The Secretary of the Department of Health, Education, and Welfare (now Health and Human Services) issued regulations that included alcoholics and drug addicts within Section 504 of the 1973 Rehabilitation Act legislation's definition of "handicap." Thus, alcoholism is, in and of itself, a disabling condition if the condition "substantially limits one or more of the major life functions."

If we believe that the estimated incidence of substance abuse in the general population is around 10-12%, it then would be safe to estimate that the percent of substance abuse and dependency in the disabled community would be at least the same figure, 10-12%. Research has indicated that this assumption would be incorrect for a number of subcategories of physical or mental disabilities. Estimates of the percent of substance abuse/dependency has ranged from 5% of the state vocational rehabilitation agency clients in 1979 to 60% in a study of clients in a vocational rehabilitation facility (Rasmussen & DeBoer, 1980-81).

Let us first look at the disabled community in general and try to make some logical assumptions about the incidence of substance abuse/dependency. The reader should be aware that these statistics are generally from state vocational rehabilitation agency case loads and may be higher or lower for persons with other disabilities in the general population.

Prior to the 1980s, only a few articles attempted to provide estimates as to the extent and nature of this problem. A number of substance abuse surveys among persons with disabilities were conducted in the early 1980s, the results of which were at best confusing. Some studies found a higher incidence of substance abuse among the disabled population, while others found lower levels of usage.

Thurer and Rogers (1984) found in a sample of physically impaired clients that 53% of them indicated that they "substantially needed" or "greatly needed" help with their substance abuse problems. Hepner, Kirshbaum, and Landes (1980-81) found that 25% of the clients served by the Center for Independent Living in Berkeley, California, abused alcohol and/or other drugs.

Research was conducted by the California Alcohol, Drug and Disability Study (CALADDS) of substance abuse and problems. A total of 123 clients were interviewed in agencies that provided services to people with various types of disabilities. Twenty-four percent of the respondents believed that they had problems with alcohol or other drugs while an additional 6% indicated that they were not sure, and 15% reported that they formerly had an alcohol or drug problem (De Miranda, 1989).

Prescribed medications are another category of substance frequently abused among persons with disabilities. The easy availability of these substances, from both physicians and other persons with access to them, increases the risk of abuse. Having a disability often requires that the person take medication, although recovery specialists note that many prescriptions for psychotherapeutic drugs are issued for their convenience rather than because they are essential

to the person's functioning (Dean, Fox, & Jensen, 1985; Schaschl & Straw, 1988).

PREVALENCE AND INCIDENCE OF SUBSTANCE ABUSE AMONG DISABILITY SUB-POPULATIONS

Traumatic Brain Injury

The incidence of intoxication, or a positive blood alcohol level, is high for persons who sustain a traumatic brain injury. It can range from 29% (Field, 1976) to 52% (Rimel & Jane, 1983) when total admissions to hospitals are considered and to 58% in surgical admissions. Apart from the frequency of intoxication, a large number of head injured surgical patients have also been found to have a history of alcohol dependence, ranging from 25% (Rimel & Jane, 1983) to 43% (Brisman et al., 1983) to 68% (Tobis, Puri, & Sheridan, 1982).

Research suggests that persons with spinal cord injury and traumatic brain injury were at high risk for pre-injury drug abuse. This problem is potentially compounded by post injury prescription of drugs with high potential for abuse. Yet even more dire are findings that point to alcohol's ability (data on drug use is not available) to exacerbate the effects of a traumatic injury.

Mobility Impairments

Most of the research dealing with substance abuse among people with mobility impairments has centered on persons with spinal cord injury (SCI). Spinal cord injury is the most frequent cause of paraplegia or quadriplegia.

Reasons for concern about substance abuse among people with mobility impairments is that substance abuse, particularly alcohol, seems to be the predisposing factor to, or at least predated, the injury. In a 1980 study of 54 people with spinal cord injury at the Montebello Center in Baltimore, researchers found that 87% had a history of substance abuse before their injury, 62% of the injuries were substance related, and 68% resumed use of substances after the injury (O'Donnell et al., 1981/82).

Other studies have implied a more immediate cause-and-effect relationship. Fullerton et al., (1981) found that 50% of 30 spinal cord injury patients admitted to the hospital had been drinking immediately prior to the accident and 5 (17%) of these reported having been intoxicated at the time of the injury.

In a number of studies, higher rates of substance abuse were found in persons with spinal cord injury than among the general population. Persons with mobility impairments have substance abuse rates ranging from 15% to 55% (Kirubakaran et al., 1986; Buss & Cramer, 1989).

Heinemann, Doll, and Schnoll (1989) conducted a study on 103 person with spinal cord injury at the Rehabilitation Institute of Chicago to determine the extent to which spinal cord injury patients recognized the need for and searched for substance abuse treatment. Of the 103

respondents, 49 (65%) indicated drinking problems prior to their injury, 4 (6%) began drinking after injury, and 20 (29%) reported no drinking problems. Fifty-five percent of the patients were intoxicated at the time of their injury and continued to drink after their injury.

Psychiatric Disability and Substance Abuse

Substance abuse and psychopathology commonly occur together. Recent literature implies that this is a growing problem for the psychiatric community at large. Persons with psychiatric disabilities and substance abuse problems are often denied services or are shuffled between substance abuse treatment programs and mental health programs without receiving adequate services.

Recent studies have found a higher rate of substance abuse among persons with psychiatric disabilities than among the general population. Psychiatric outpatients have rates of substance abuse, ranging from 17% to 63%, with emergency department patients having the highest rate among outpatients. (Battki, 1990; Weissman et al., 1980; Reichler et al., 1983; Motet-Gringoras & Schuchit, 1986).

Hearing Impairment

There is a significant lack of research concerning substance abuse, deafness, and hearing impairments. However, a few studies have attempted to estimate the prevalence of substance abuse among people who are deaf. These estimations have been made on the assumption that substance use is at least as common in the hearing impaired population as it is among the general population.

According to Wentzel (1986) and the U.S. Bureau of the Census (1987), there are more than 20 million persons with hearing impairments in the United States. The question we must ask is how many are also substance abusers? Dixon (1987) estimated that approximately 20% of the hearing impaired population were chemically dependent.

The incidence of substance abuse among persons who are deaf has received some attention. McCrone (1982) estimated that there are approximately 73,000 deaf alcoholics, 8,500 deaf narcotic addicts, 14,700 deaf cocaine/crack users, and 110,000 deaf marijuana users. Steitler (1984) believed that substance abuse may be even a greater problem in the deaf community; she estimated that one million deaf people in the United States need professional help for substance abuse.

These findings indicate at least moderate levels of use among persons with hearing impairments. The difficulty comes in trying to interpret this data, because the deaf community has traditionally considered substance abuse as a moral defect and has been inclined to keep this problem hidden (Sylvester, 1986; Sabin, 1988). Boros (1981) states, "The deaf already have the burden of the stigma 'deaf and dumb'; now they shirk from any imposition of the added label of 'deaf and drunk."

Wentzel (1986) refers to deaf alcoholics as the doubly isolated, people with a lonely handicap and a lonely disease.

Visual Impairment

People with visual impairments have received the least attention in regard to substance abuse. According to Peterson and Nelipovich (1983), the estimated number of person with visual impairments and substance abuse is 40,000 among the 500,000 visually impaired people in the United States.

A recent survey conducted by the Office for Persons with Disabilities in Wisconsin suggested the existence of a serious substance abuse problem within the visually impaired community (Buss & Cramer, 1989). The levels of substance abuse within this study were considerably higher in comparison to a national general population survey conducted by Cahalan, Cisin, and Crossley (1969). Twenty-seven percent of the persons with visual impairments indicated that they were abstainers compared to 32% in the general population. Thirty-three percent of the persons with visual impairments indicated that they were infrequent or light drinkers, compared with 43% in the national survey. However, when combining the moderate and heavy drinking categories, 40% of persons with visual impairments indicated that they were moderate or heavy drinkers, compared with 25% in the general population survey.

Developmental Disabilities

Under the category heading of developmental disabilities is a variety of functionally limiting conditions which usually appear during childhood or adolescence, such as mental retardation, cerebral palsy, autism, epilepsy, learning disabilities, and neurological disorders. A review of the recent literature finds only a few articles have been written in the area of substance abuse relative to this population. Sengstock, Vergason, and Sullivan (1975) noted, "Despite the lack of objective research in this area, special education teachers have reported that they have observed the problem in their classes." However, no data had been reported to support this claim. There have been some clinical reports that have revealed heavy alcohol use among some persons with mental retardation (Delaney & Poling, 1990; Krishef & DiNitto, 1981). However, recent research indicates that mentally retarded persons do not have unusually high levels of alcohol or other drug use.

In an ethnographic study designed to determine the effects and extent of substance abuse among people with mental retardation, Edgerton (1986) found that the majority did not use or engage in use-related activities, even though most had easy access to alcohol or other drugs or associated with substance abusers. Of those that did use substances, few became dependent. Thirteen of the 181 (7%) of those surveyed engaged in heavy use. Besides alcohol, only marijuana was used regularly.

In the first study conducted to compare the drinking behavior of students that were educable mentally retarded with students that were not mentally retarded, Huang (1981) found few significant differences between the two groups. Both groups reported rates lower than the national average. There is, however, considerable concern among some professionals that this problem will worsen. Many more people with mental retardation are moving into the community earlier in their lives with limited support. This may increase the potential risk for substance abuse problems, particularly since alcohol and illicit drugs adversely interact with their prescribed medication (Westermeyer, Phaobtong, & Neider, 1988).

Learning Disabilities

Under this category a varied list of problem areas can be found: visual, communication, auditory, and the one most often studied, attention deficit hyperactivity disorder (ADHD). Attention deficit hyperactivity disorders have been estimated to affect 4% to 10% of the general population. This disorder is characterized by impulsivity, hyperactivity, developmentally inappropriate attention seeking, low self-esteem, aggression, low tolerance of frustration, and poor academic achievement. Many of these characteristics have been identified as possible risk factors for later-life substance abuse. Kramer and Loney (1982) found a correlation between childhood hyperactivity and alcoholic adults. Hechtman, Weiss, and Perlman (1984) suggested that an identifiable subgroup of alcoholics was also hyperactive as children.

The question most often asked is whether persons with disabilities use and abuse substances more frequently than the general population. However, the question professionals must ask is, "What is the effect and nature of this use?"

THE EXPERIENCE OF ADDICTION

The vocational rehabilitation counselor working with consumers with coexisting disabilities will be challenged to an extent not usually found with other consumers. The prevalence and incidence data highlight the frequency in which substance abuse is likely to be encountered coexisting with other disabilities. Thus it is imperative that the counselor understand the nature of addiction.

Addiction is defined by the following essential characteristics:

1. Loss of control over the use of a mood altering substance, and

2. The continued use of the substance despite negative consequences.

Withdrawal symptoms of a physical nature may or may not accompany cessation of the use of the substance. This is why the term chemical dependency has been substituted for the term addiction in the Diagnostic and Statistical Manual of Mental Illness, Third Edition, Revised (DSM III-R). (The complete DSM III-R definition of chemical dependency and abuse will be reviewed in Chapter II.)

What is it like to be chemically dependent on a drug or alcohol? It is important for the vocational rehabilitation counselor to have some understanding of addiction in order to better serve the consumer with coexisting disabilities. Addiction has to do with obsessive/compulsive conditioned habits. It is not difficult to identify examples that are common experiences to many persons. For example, if you have ever been on a diet you have some understanding of what it is like to obsessively think about, and compulsively use, a drug. Hunger for food is similar to the craving addicted persons experience for their drug of choice.

If you are like many who have gone on a diet, only to break the diet prematurely, you will have experienced a relapse similar to relapsing on alcohol or drugs. Note how difficult it

is to get back on the diet immediately after relapsing, which is similar to the experience of recovering alcohol and drug addicts. It is important to note that dieters who relapse and eat what they want will experience satiation (the satisfying feeling which eliminates hunger). Addicts do not ever reach that satiated, full feeling. As the AA saying aptly explains, "One drink is too many, and a thousand is not enough." The crack cocaine addicted, heroin user, alcoholic, or prescription drug abuser will crave for their chemical as much or more after a binge than before he/she took the first drink, hit of cocaine, heroin, or valium. In short, addiction is no fun.

So-called "recreational use" may be fun, but the addict is a desperate, out-of-control person who would trade places with a person not addicted if he/she could magically do so. Like a fictional Dracula who craves and experiences temporary relief once fed, but is doomed to living the life of the living dead, the addicted person is unhappy, depressed, and isolated from the life of normal drug-free living.

It is important for the vocational rehabilitation counselor to realize that addicts did not cause their addiction, cannot control their use of the drug or alcohol, and can not cure their addiction. While many people choose to use alcohol and drugs, only a small percentage (perhaps 10-12%) become addicted. Of course, this percentage drastically increases for certain highly addictive drugs like crack cocaine and heroin. Addiction is not a choice. There is more to abstaining from alcohol and drugs once the person has become addicted than "just saying no." This becomes particularly challenging for the person who has a coexisting disability.

In order to stabilize the substance dependent disability, much will be required of the person in terms of commitment, following advice, and spirituality. While the persons did not choose to become addicted, they must choose to become abstinent. That is, they must choose to use the tools and rules of recovery that will slowly, and often painstakingly, lead them to the state of full remission of the symptoms of substance dependence. A glimpse of this journey will be briefly reviewed, with a more detailed coverage provided in the following chapters.

COURSE OF ADDICTION

The course of addiction follows a highly predictable pattern (see Figure I-1).

The introductory phase of drug use is the "recreational" or "honeymoon" phase. The length of this phase varies from person to person and from drug to drug. However, the end of the phase is similar across persons and drugs. When the person begins to experience negative consequences due to the substance use (e.g., staying out too late, spending too much money, engaging in atypical promiscuous behavior, etc.) the honeymoon is over and abuse is recognized.

The abuse phase is characterized by broken promises to self and others. Family members begin to notice a change in the abuser's routine, reliability, and trustworthiness. Problems caused by the substance continues to worsen to the point that job performance is affected (e.g., absenteeism, tardiness, lower productivity). At some point during the abuse phase the person "crosses the line" of addiction. It is significant to note that the person does not know when he/she have moved from abuse to addiction. It is when the abuser tries to stop using

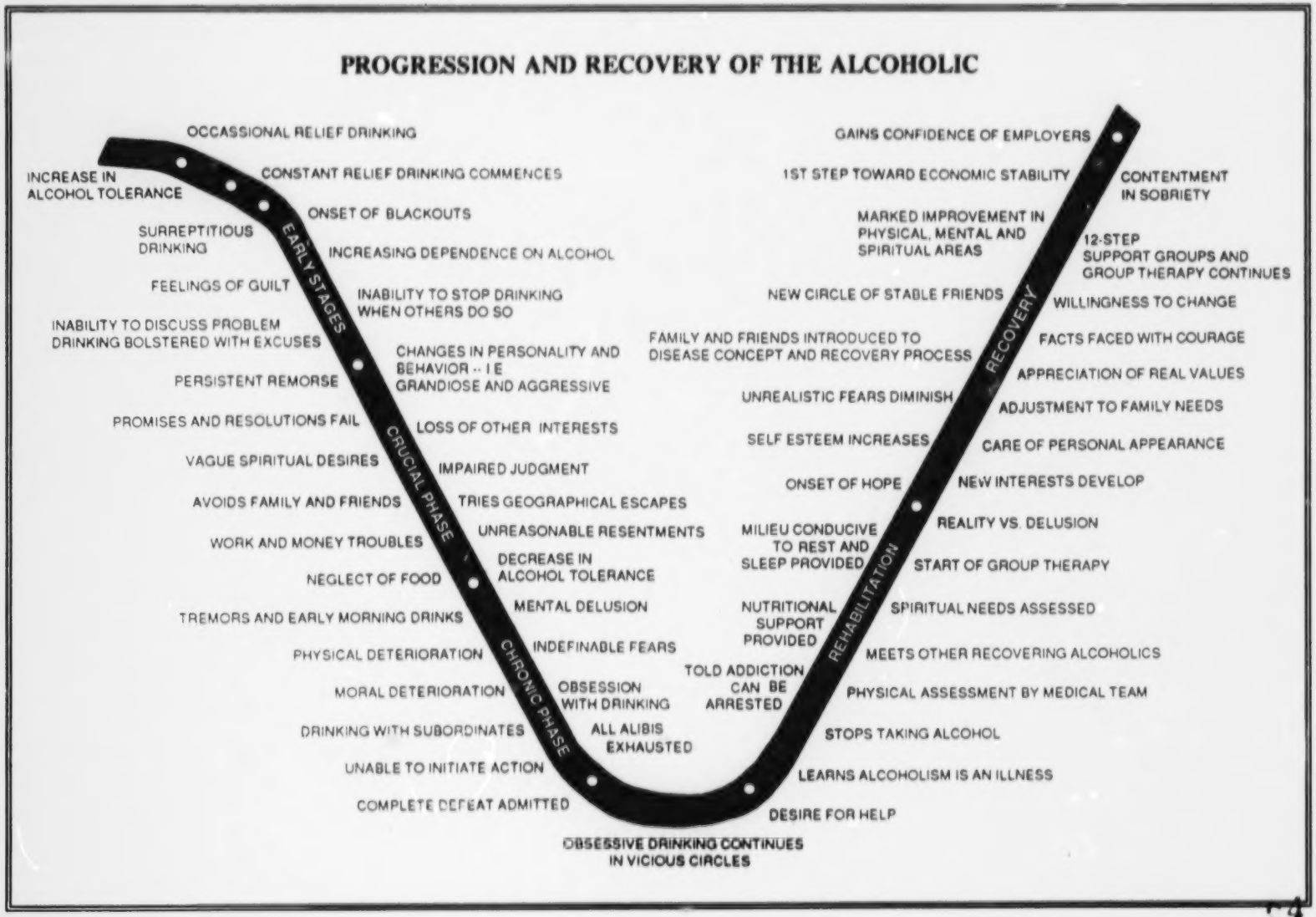
PROGRESSION AND RECOVERY OF THE ALCOHOLIC
OCCASSIONAL RELIEF DRINKING
INCREASE IN ALCOHOL TOLERANCE
CONSTANT RELIEF DRINKING COMMENCES
ONSET OF BLACKOUTS
SURREPTITIOUS DRINKING
INCREASING DEPENDENCE ON ALCOHOL
FEELINGS OF GUILT
INABILITY TO STOP DRINKING WHEN OTHERS DO SO
INABILITY TO DISCUSS PROBLEM DRINKING BOLSTERED WITH EXCUSES
CHANGES IN PERSONALITY AND BEHAVIOR -- I E GRANDIOSE AND AGGRESSIVE
PERSISTENT REMORSE
PROMISES AND RESOLUTIONS FAIL
LOSS OF OTHER INTERESTS
VAGUE SPIRITUAL DESIRES
IMPAIRED JUDGMENT
AVOIDS FAMILY AND FRIENDS
TRIES GEOGRAPHICAL ESCAPES
WORK AND MONEY TROUBLES
UNREASONABLE RESENTMENTS
NEGLECT OF FOOD
DECREASE IN ALCOHOL TOLERANCE
TREMORS AND EARLY MORNING DRINKS
MENTAL DELUSION
PHYSICAL DETERIORATION
INDEFINABLE FEARS
MORAL DETERIORATION
OBSESSION WITH DRINKING
DRINKING WITH SUBORDINATES
ALL ALIBIS EXHAUSTED
UNABLE TO INITIATE ACTION
COMPLETE DEFEAT ADMITTED
OBSESSIVE DRINKING CONTINUES IN VICIOUS CIRCLES
EARLY STAGES
CRUCIAL PHASE
CHRONIC PHASE
GAINS CONFIDENCE OF EMPLOYERS
1ST STEP TOWARD ECONOMIC STABILITY
CONTENTMENT IN SOBRIETY
MARKED IMPROVEMENT IN PHYSICAL, MENTAL AND SPIRITUAL AREAS
12-STEP SUPPORT GROUPS AND GROUP THERAPY CONTINUES
NEW CIRCLE OF STABLE FRIENDS
WILLINGNESS TO CHANGE
FAMILY AND FRIENDS INTRODUCED TO DISEASE CONCEPT AND RECOVERY PROCESS
FACTS FACED WITH COURAGE
APPRECIATION OF REAL VALUES
UNREALISTIC FEARS DIMINISH
ADJUSTMENT TO FAMILY NEEDS
SELF ESTEEM INCREASES
CARE OF PERSONAL APPEARANCE
ONSET OF HOPE
NEW INTERESTS DEVELOP
MILIEU CONDUCIVE TO REST AND SLEEP PROVIDED
REALITY VS. DELUSION
START OF GROUP THERAPY
NUTRITIONAL SUPPORT PROVIDED
SPIRITUAL NEEDS ASSESSED
MEETS OTHER RECOVERING ALCOHOLICS
TOLD ADDICTION CAN BE ARRESTED
PHYSICAL ASSESSMENT BY MEDICAL TEAM
STOPS TAKING ALCOHOL
LEARNS ALCOHOLISM IS AN ILLNESS
DESIRE FOR HELP
REHABILITATION
RECOVERY

Figure I-1

permanently (not simply slow down) and fails that the true meaning of addiction begins to register.

During the addiction phase the addict's life is characterized by severe marital, familial, vocational, financial, emotional, and sometimes legal difficulties. The end point of this phase in AA terminology is the choice of abstinence, insanity, incarceration, or death.

Views of Addiction

While each view of addiction has similarities, i.e., that addiction leads to tolerance, withdrawal (physical and/or psychological), and loss of control, there are significant differences. The important point for vocational rehabilitation purposes is that the Rehabilitation Act defines addiction as a disability.

Disease concept. The disease concept of addiction defines chemical dependency as an illness (i.e., disease) which is primary, progressive, chronic, and terminal unless arrested. According to the disease concept, chemical dependency is primary in that it is not a secondary symptom of an underlying disorder (e.g., personality disorder), progressive in that it gets progressively worse if not treated, chronic in that there is no known cure, and terminal in that it will cause death if not arrested.

Addiction as a functional disorder. Addiction seen as a functional disorder indicates that addiction is due to environmental conditions which causes significant stress of a chronic nature in a person's life. The addicted individual is believed to be exhibiting symptoms of the underlying environmental conditions--the symptoms being the addictive use of alcohol and drugs. This functional definition of addiction suggests that if the environment is improved (for example, eliminate poverty, provide decent housing, food and clothing, or provide adequate health care services) then the person would no longer use addictive drugs (Bell, 1990).

Genetic model of addiction. A corollary to the disease model of addiction is the genetic model of addiction. This model suggests that certain persons are genetically predisposed to abuse mind- or mood-affecting substances. The genetic concept of addiction suggests that the person is vulnerable to addiction no matter what the substance is, that is, as mild as marijuana or as addicting as crack cocaine. The genetic concept of addiction also suggests that the environment plays a minimal role. For example, the person could live in a stable home environment and neighborhood or in a dysfunctional home and neighborhood environment (Bell, 1990).

COMMONLY USED TERMS

The following is a list of commonly used terms in addiction. These terms are important to understand in order to understand addiction.

Relapse. Relapse is part of the recovery for many substance dependent persons. Whether the drug is licit, (e.g., nicotine) or illicit (e.g., heroin), relapses are an expected phenomenon. Relapse occurs between the time persons begin the attempt at abstinence to the time the drug is used for the last time. The craving for the drug is so powerful most addicted

persons will succumb to its allure even after sincerely committing to abstinence. For persons involved in a treatment program (in- or outpatient), multiple relapses can be a part of the recovery process because it helps the person break through denial of substance abuse.

Cross-addiction. Cross-addiction occurs when a person attempts to abstain from the use of one drug, e.g., crack cocaine, by substituting the use of another drug, e.g., alcohol, which leads to alcoholism. The person's failure to develop healthy coping mechanisms contributes to the development of cross-addiction.

Denial. Denial is a psychological defense mechanism which allows persons to function while under stress. Substance dependent persons in denial reject the idea that they are addicted and/or that they must utilize the rules and tools of recovery (primary of which is total abstinence) if they are to be successful in abstinence. Primary types of denial in substance abuse are: (a) minimizing the seriousness of substance dependence; (b) lying about the fact of substance use; (c) avoiding responsibilities, e.g., failure to keep drug treatment appointments; and (d) blaming others or circumstances for their addiction.

Reaching one's "bottom." The concept of reaching one's "bottom" refers to the observation that until the addicted individual gets "sick and tired of being sick and tired" they will continue to use. There comes a time (which differs from person to person) when the substance dependent persons have experienced enough pain and suffering that they feel that either they start working on their recovery or they will die. This is the point in the course of addiction that the person decides to abstain, go to treatment, and follow the advice of successfully recovering persons because they (the addicts) want to recover, not because others want them to recover. Unfortunately for many persons, reaching their "bottom" happens after they have lost their family, friends, job, self-respect, sometimes their health, and sometimes their freedom.

Codependency. The concept of codependency developed as a result of treatment professionals evaluating how nonalcoholic family members were affected by the alcoholism of a family member. The term codependency later came to include exposure to life in any dysfunctional family. Codependency occurs as the family member(s) or other involved person(s) e.g., vocational rehabilitation counselor, sees the addicted person destroy him or herself. A common codependent behavior is seen in the over-protective person (the enabler).

Enablers help the addict continue chemical dependency. He/she enables the addict to avoid the negative consequences of addiction and thus increase the time it takes the person to reach their "bottom." A less recognized but codependent behavior none-the-less is the codependent who expresses negative opinions which feed into negative stereotypes and myths about the addict. This person allows the addicts to reach their "bottom" (in fact may even speed them along) but offers little if any assistance when the person asks for help. This contributes to prolonging the time spent on the "bottom."

Professionals who work with addicted persons are at high risk for co-dependency. Medical doctors can contribute to continued chemical dependency (e.g., prescription drug addiction) as well as cross-addiction (e.g., prescribing anti-anxiety drugs to recovering alcoholics). Vocational rehabilitation counselors are at risk for codependency by doing too much

or too little for the client.

> Jan is a forty year old woman with a T-12 spinal cord injury. She was paralyzed in 1967 when 16 years old due to an automobile accident. She was passed out in the back seat while a friend also under the influence of alcohol was driving. While in the hospital "rehabilitating":
>
> I became addicted to legal prescription drugs such as, sleeping medication, Valium, and all sorts of pain medication. What ever Jan wanted Jan got. These doctors imagine that life must be terrible for someone like me. When I burned out all of my physician contacts and couldn't get drugs I became a full blown alcoholic. I fell out of my wheelchair on a regular basis, called people all night, totaled my car in a blackout, and broke my leg falling out of my wheelchair in another blackout. In the last year of using alcohol and other drugs I spent about $70,000 from my injury settlement.

Remission and eligibility. Remission means the abatement of symptoms for a period of time. Full remission means "there are no longer any symptoms or signs of the disorder" (DSM III-R, 1987, p. 24). Partial remission (residual state) means "the full criteria for the disorder were previously met, but currently only some of the symptoms or signs of the illness are present" (DSM III-R, 1987, p. 24). The addicted person in full remission no longer abuses alcohol or drugs, and it is anticipated that the person will continue to be free of alcohol and drug abuse for the foreseeable future. The differentiation of "in full remission" from "recovered" (no current mental disability) requires consideration of the length of time since the last period of disturbance, the total duration of the disturbance, and the need for continued evaluation or prophylactic treatment (DSM III-R, 1987, p. 24).

Is the person addicted to alcohol or drugs but in full remission eligible for vocational rehabilitation services? When addiction is a coexisting disability (in full remission) the problem of eligibility for vocational rehabilitation services becomes less complicating because eligibility can be based on the remaining disability.

Many counselors are concerned about whether chemical dependency in full remission constitutes any vocational handicap(s) that would affect getting a job. Two common questions are: (a) does the person who has been abstinent from alcohol abuse for several years (alcohol dependence in full remission) continue to have vocational handicaps related to alcoholism? (This question is relevant whether there is a coexisting disability) and (b) should the person be considered recovered and thus no longer disabled due to alcohol dependence?

Answering the second question first, addiction is considered a chronic disease and thus incurable. While this position is not unanimously held by addictionologists, it is apparently the position endorsed by the DSM III-R. This position (i.e., the disease definition of addiction) is also held by the American Medical Association, American Psychiatric Association, World Health Organization, American Psychological Association, American Medical Society on Alcoholism and Other Drug Dependency, to mention a few (Michael et al., undated).

When a person is in full remission from chemical dependence, i.e., no signs of chemical

dependence for the past six consecutive months, and there is an expectation that the person will remain abuse free for the foreseeable future, a significant level of stability has been achieved. However, vocational handicaps related to the chemical dependency may still persist. The threat of relapse may be significant enough to be addressed in the treatment planning. Remember, if abstinence is stable, but maintained via prophylactic (i.e., preventative) activities, such as attending A.A. meetings or avoiding alcohol and/or drugs, vocational handicaps may be indicated. For example, persons with years of substance abuse dating back to adolescence (even though currently in full remission) often have not learned social skills (e.g., the art of negotiation, conversation, or etiquette); may not have learned to recognize or process emotions; and have no practice in the exercise of patience, tolerance, or delayed gratification (Michael et al., undated). The severity of these deficits may meet the criteria for a personality disorder. If not, they could be at least severe enough to be barriers to employment.

PERSONAL/SOCIAL ATTITUDES ABOUT SUBSTANCE ABUSE

A counselor's attitude about substance abuse influences the quality of services provided. Thus, it is important for counselors to be aware of myths that may influence the way the addicted person is perceived and treated.

Alcohol

A common myth, perhaps the most popular myth about chemical dependency, is that the chemically dependent person is a person of weak moral character. A chemically dependent person is seen as deserving what he/she gets for willfully engaging in risky behavior. These individuals are seen as responsible for their addiction and as choosing to use the drug despite consequences. A basic assumption of this myth is that chemically dependent persons have control over whether they use the drug or whether they "just say no." A corollary of this myth is that the chemically dependent person really doesn't want to stop using the drug.

Another myth is that if chemically dependent persons really wanted to stop abusing the drug, they could. These individuals are seen as pleasure seekers, irresponsible, and basically morally weak, sneaky, manipulative, lazy, and corrupt individuals. They are perceived as choosing to remain addicted and avoid the challenging task of behaving in a mature and responsible manner.

The following quote is from Brad, a poly drug user:

> Being addicted to heroin, was like having a monkey on your back. Being addicted to Methadone was like having a Gorilla on your back. But to be addicted to loads (Doriden and Codeine) was like having the whole damned zoo on your back!

Another myth concerning chemically dependent persons is that they are low-income, poorly educated, usually young African-American males, or more recently Hispanic, and criminally oriented. These individuals, according to the myth, do not succeed in treatment because they are not motivated to recover. The myth goes on to prescribe punishment as the

response of choice rather than rehabilitation which will ultimately curb the use of the drug. A corollary to this myth is that incarceration should be the "treatment" of choice rather than therapeutic intervention. This myth also describes persons who are addicted as never wanting anything out of life and probably will never get anything out of life. Thus they are seen as hopeless cases, and vocational rehabilitation services are a waste of taxpayers' dollars.

There is also the myth that addicted persons have underlying antisocial personality disorders. These sociopathic individuals are seen as thrill seekers, manipulators, and poor candidates for employment even if they were not addicted to drugs. This stereotype make it seem as if these persons were dropped on this earth from another planet, having no history of innocence, no explanation for their problems, and no hope for their future.

As a result of the above myths, many counselors believe that if there is a disability, it was caused by the willful use of harmful chemicals. The reasoning goes something like this: If the disability was caused by the addiction, which is the willful use of a harmful substance, and the person could decide to stop using that substance, thus eliminating the disability, then why should tax dollars be spent on expensive rehabilitation that could be achieved by simply "saying no"? This reasoning is like saying a person is blind because he/she chooses to close her/his eyes. Why should taxpayers pay for rehabilitation for this "blind" person when all the person has to do is to decide to open his/her eyes and thus eliminate the disability. As we have seen in the discussion on the nature of addiction, it is obvious that these myths are just that--myths. They are falsehoods; they distort reality; they are based on erroneous premises and thus lead to false conclusions.

Mental illness in the nineteenth century was considered the product of demonic possession and thus evil. The person with mental illness was burned at the stake, beaten mercilessly, or drained of blood as a way of ridding the body of evil humors. Present-day myths of chemical dependency and the chemically dependent person smacks of medieval thinking, ignorance, and in many instances prejudice and racism. It is hoped that as counselors read this manual they will do a self-inventory of their beliefs, opinions, and assumptions about addiction. They can identify those attitudes which are in need of modification and updating and those in need of discarding.

Crack Cocaine

Crack cocaine addiction is another area in which myths and miseducation abound. It is believed by many that persons addicted to crack cocaine fit the mythical profile already associated with substance abusers.

A related myth is that persons addicted to crack cocaine cannot recover. Another myth is that crack cocaine is a "mind thing." When people on the street say this, they tend to suggest that they are choosing to use crack and that they have control over this use. Once they decide not to use crack, they simply have to make up their mind not to use crack. This is a variant on the will power theme of addiction; that is, all one needs is a strong will power to recover from addiction. This myth has lead to many persons never recovering from addiction because as we will see, recovery from addiction involves spirituality, mentality, and physicality.

Other misstatements focus on erroneous beliefs held by substance abusers or about persons who have substance abuse as a coexisting disability:

1. **Statement**: Everything will be okay as long as we ignore it.

   Fact: Addiction is an insidious and a progressive disease if intervention does not occur.

2. **Statement**: One drink or one snort of coke won't hurt me.

   Fact: One use is too many and a thousand is not enough.

3. **Statement**: I have one more drunk left in me.

   Fact: We may have one more drunk left but we don't know if we have another recovery.

4. **Statement**: My alcoholism/drug addiction only affects me!

   Fact: Alcoholism/drug addiction affects everyone associated with the addict/alcoholic.

5. **Statement**: Alcoholism/drug addiction only affect certain people. Addictions only affect certain classes/races of people. Addictions don't affect people of certain religions.

   Fact: Alcoholism affects all races, religions, classes, sexes, and people of all economic conditions.

These misstatements have as a common thread the operation of denial which allows the person to engage in dysfunctional substance abuse and feel okay about it.

The following beliefs about persons with substance abuse as a coexisting disability highlight the effect of the stigma of physical or psychiatric disabilities. These beliefs demonstrate how we devalue and underestimate the abilities and potentialities of persons who have special challenges to overcome.

1. **Belief**: People with disabilities are too nice to use drugs or alcohol in an "unsocial manner."

2. **Belief**: People with disabilities have nothing better to do with themselves. "If I had a disability I would want to be loaded the rest of my life." As most of us know, our society places little value on the abilities of people with disabilities and older people.

3. **Belief**: Someone with a disability can achieve physical and/or psychological rehabilitation while they are still using alcohol and/or other drugs.

4. **Belief**: A person who has just acquired a major "life limiting" disability as a result of addiction can't become more disabled by continuing to use.

5. **Belief**: People with disabilities should not be held to the same standards we hold to others.

TREATMENT PROGRAMS

Treatment programs that are available involve both inpatient and outpatient programs. Short-term inpatient programs called detoxification programs are usually a week long and available on a first-come, first-serve basis, without charge. Persons, while in a detoxification unit, will have an opportunity to be in a drug free environment, allowing their body to metabolize ingested drugs out of their system, and at the same time these persons will be exposed to drug education and some drug counseling.

Longer residential programs, but still short-term, are called 28-day programs. Health insurance carriers will usually not pay for more than 28 days of treatment. Some authorities call these programs short-term treatment programs while others call them residential treatment programs. This is the most common type of treatment program, and the resident usually pays for the treatment either through insurance or out of pocket for services.

Short-term (28-day) programs allow persons not only to detox but also to deal with drug education issues and initial drug treatment issues. Persons are expected to address whether or not they have accepted that they are addicts and that they have no control over their use of the drug. During the stay, the persons attend individual and group counseling sessions in which negative attitudes are confronted and hopefully weakened. Relapse rates for persons discharged from short-term programs are quite high, over 80% in some reports.

Long-term residential drug programs provide stays of six months or more, and include detoxification services, drug education, and drug counseling services. In addition, these programs often deal with vocational issues, family issues, and health issues.

Myths about these programs vary from those that suggest that graduating from a 28-day residential drug program should result in a "cured" or "recovered" person to the myth that treatment does not work at all for drug addicts. The first myth suggests that when the person relapses upon reentry into the community, it means that the person has decided to resume using. Thus, they should suffer the consequences of this use including punishment and incarceration if necessary. For example, in criminal cases of felony drug offenders, judges will often violate a person's probation and incarcerate her/him if while on probation he/she has graduated from a 28-day drug program and then relapsed. This relapse is seen as evidence that the person does not really want to recover and thus should receive punishment in the form of incarceration instead of continued treatment. On the other side of the coin, the myth that suggests that treatment does not work has resulted in many persons who historically have not been served by the treatment community to have low motivation to seek treatment. When they do seek treatment, they do so at a more deteriorated state of addiction.

Treatment not only has to work with persons with little belief in the efficacy of treatment but also has to work with persons who are more severely addicted by the time they seek treatment. When these individuals fail treatment, the treatment receives the stigma of being ineffective without considering the context in which treatment was received. As mentioned earlier, a person who has tried treatment is the person who has worked to grow spiritually, accepts responsibility for her/his addiction and recovery, and follows the advice of treatment agents.

MY USE VERSUS CLIENT'S USE

Counselors may establish more empathy with substance abusers if they can identify addictive traits in their own lives. For example, looking at tobacco use, caffeine use, overeating, etc., can provide an avenue of greater understanding of the difficulty of abstaining from addictive behavior. Persons who have experienced dysfunctional and sometimes abusive love relationships may empathize with substance abuse and addiction. It is important to recognize that addiction is insidious. That is, persons usually do not know when they have crossed the line from substance use, to abuse, and finally to addiction. In fact, one will usually recognize abuse quicker than addiction.

Abuse occurs when a person uses alcohol or drugs despite negative consequences. Addiction includes abuse but also the inability to stop using even though desiring to do so. The point at which the person has lost control of her/his use is usually an invisible line. Thus, the person who makes excuses and says "I can stop when I want to, but I just don't want to stop" may be operating in the early stage of addiction which is characterized by massive denial and dissociation of the use of the drug from the consequences of its use.

If a counselor drinks rather heavily he/she might have difficulty seeing the difference between his/her drinking and the client's abusive drinking. To accept that the client has a drinking problem might mean accepting that the counselor should examine his/her own drinking, and this can be personally threatening.

Also, there are counselors who come from an alcoholic or drug using family where one or both parents used abusively. Such an early environment can severely affect a child's (later adult's) image of substance abusers, with resulting attitudes ranging from total and hostile rejection of the client to an enabling protectiveness.

Finally, the counselor who does not drink at all, and is opposed to any person's drinking to any degree, can have a serious problem accepting the client as a person deserving of services or able to receive services.

CASE STUDY

In place of a summary, the following abbreviated case study is presented. They are the words excerpted from those of a vocational rehabilitation counselor who is blind and a poly drug user. He grew up in a family that abused alcohol. He began drinking at age 15 "beginning with

Boons Farm apple wine and graduating on to Southern Comfort." From his autobiography he was obviously able to complete graduate school in spite of his substance abuse.

> High School ended in a blur and fog of ever increasing pot smoke. Secrecy was tightly maintained at home while my father's drinking became more obvious to me and served as a rationale for my smoking pot.
>
> The summer between high school and college was another peak drug and alcohol experience. In the summer of 1972, 72 blind students held the longest party on record (was in a college prep program for blind students). I entered college with a hangover, a lust for excitement, no career direction, and very little desire to study. Drinking and drugging pervaded my college years. It gave me additional income as I began to dabble in small time sales and reduced my own overhead by covering the cost of my own drugs. Graduate school took me to XXX and more of the same party mentality.
>
> Working life took the place of spirituality. I concentrated my energy on applying my knowledge of rehabilitation counseling in my new career. As a role model, I was viewed as independent, successful, and worthy of professional commendation. I balanced the night time excursions into oblivion with my day time responsibilities. My initial emphasis in the field of rehabilitation was on working with individuals with psychiatric disabilities. I somehow felt akin with my clients who appeared as mysterious and secretive as I needed to be.
>
> Blindness for me had always been a mix of inconveniences and devastating social struggles. Blindness at the work place was supposed to be an asset because of the potential for transferring empathy to other people with disabilities. Yet, at work, I felt like a symbol of disability for an office that had no other staff with disabilities. I never felt valuable enough as a person with a disability to advocate for my own needs with any measure of strength or sense of credibility. How could I then be of any major benefit to the scores of clients with disabilities I was expected to share my own successes with? I felt wrapped up in contradiction and clothed in the costume of an imposter.
>
> My work took a new direction. I began seeing more clients in recovery from alcoholism. Their stories were my story and I often felt on the wrong side of the desk. In 1987, a training program for counselors was held on the topic of adult children of alcoholics and the impact the syndrome of behaviors may have on self concept.
>
> Finally, in June of 1988 I began attending Al-Anon, Adult Children Twelve Step meetings and began my process of recovery. Without sounding like a glazed eyed, mesmerized follower of a cult religion, I feel there is a lot to be gained in forgiveness, self respect, and faith. For these concepts have restored my life to sanity and now give me the strength to carry on.

REFERENCES

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed., revised). Washington, DC: Author.

Bell, P. (1990). Chemical dependency and African-American: Counseling strategies and community issues. Hazelden Education Materials. Pleasant Valley Rd., Center City, MN.

Boros, A. (1981). Activating solutions to alcoholism among the hearing impaired. In A. J. Schecter (Ed.), Drug Dependence and Alcoholism, Vol. 2. Social and Behavioral Issues (pp. 1007-1014). New York: Plenum Press.

Brisman, B., Engstrom, A., & Rydberg, U. (1983). Head injury and intoxication: A diagnostic and therapeutic dilemma. Acta Chirurgica Scandinavica, 149, 11-14.

Buss, A., & Cramer, C. (1989). Incidence of alcohol use by people with disabilities: A Wisconsin survey of persons with a disability. Madison, WI: Office of Persons with Disabilities, Department of Health and Social Services.

Cahalan, D., Cisin, I. H., & Crossley, H. M. (1969). American drinking practices. New Brunswick, NJ: Publications Division, Rutgers Center of Alcohol Studies.

Carney, N. C. (1991, March). National Rehabilitation Association Newsletter, pp. 8-9.

Collado-Herreel, L. I. (1980). Cited in Prevention and ethnicity: Current research. Florida Alcohol and Drug Abuse Association.

De Miranda, J. (1989). California alcohol, drug, and disability study final report. Sacramento: Licensing and Certification Section, Department of Alcohol and Drug Programs.

Dean, J. C., Fox, A. M., & Jensen, W. (1985). Drug and alcohol use by disabled and nondisabled persons: A comparative study. International Journal of the Addictions, 20(4), 629-641.

Delaney, D., & Poling, A. (1990). Drug abuse among mentally retarded people: An overlooked problem? Journal of Alcohol and Drug Education, 35(2), 48-54.

Dixon, T. L. (1987, February). Addiction among the hearing impaired. EAP Digest, pp. 41-44, 77.

Drug Free Schools and Communities. (1988). FADA, 2(1).

Edgerton, R. B. (1986). Alcohol and drug use by mentally retarded adults. American Journal of Mental Deficiency, 90(6), 602-609.

Evans, K., & Sullivan, J. M. (1990). Dual Diagnosis, Counseling The Mentally Ill Substance Abuser. New York: Gilford Press.

Field, J. (1976). Epidemiology of the head injury in England and Wales: With particular application to rehabilitation. Leicester: Printed for H. M. Stationary Office by Willsons.

Fullerton, D.T., Harvey, R. F., Klein, M. H., & Howell, T. (1981). Psychiatric disorders in patients with spinal cord injuries. Archives of General Psychiatry, 38, 1369-1371.

Harper, F. (1975). Prevention and ethnicity: Current research. Tallahassee, FL: Alcohol and Drug Abuse Association, (FADA) Resource Center.

Hechtman, L., Weiss, G., & Perlman, T. (1984). Hyperactives as young adults: Past and current substance abuse and antisocial behavior. American Journal of Orthopsychiatry, 54, 415-425.

Heinemann, A., Doll, M., & Schnoll, S. (1989). Treatment of alcohol abuse in persons with recent spinal cord injuries. Alcohol Health and Research World, 13(2), 110-117.

Hepner, R., Kirshbaum, H., & Landes, D. (1980/81). Counseling substance abusers with additional disabilities: The Center for Independent Living. Alcohol Health and Research World, 5(2), 11-15.

Huang, A. M. (1981). The drinking behavior of the educable mentally retarded and nonretarded students. Journal of Alcohol and Drug Education, 26(3), 41-50.

Kirubakaran, V. R., Kumar, V. N., Powell, B. J., Tyler, A. J., & Armatas, P. J. (1986). Survey of alcohol and drug misuse in spinal cord injured veterans. Journal of Studies on Alcohol, 47(3), 223-227.

Kramer, J., & Loney, J. (1982). Childhood hyperactivity and substance abuse: A review of the literature. In K. D. Gadow, and I. Bailer (Eds.), Advances in learning and behavioral disabilities: A research annual, Vol. 1 (pp. 225-260). Greenwich, CT: JAI Press. pp. 225-260.

Kraus, L. E., & Stoddard, S. (1989). Chartbook on disability in the United States. An InfoUse report. Washington, DC: National Institute on Disabilities and Rehabilitation Research, U.S. Department of Education.

Krishef, C. H., & DiNitto, D. M. (1981). Alcohol abuse among mentally retarded individuals. Mental Retardation, 19(4), 151-155.

Michael, J. H., Miller, J. H., & Mulkey, S. W. (undated). Vocational rehabilitation and chemically dependent youth: Eligibility determination and the IWRP. Knoxville, TN: Regional Rehabilitation Continuing Education Program, The University of Tennessee.

McCrone, W. P. (1982). Serving the deaf substance abuser. Journal of Psychoactive Drugs, 14(3), 199-203.

Motet-Gringoras, C. N., & Schuchit, M. A. (1986). Depression and substance abuse in handicapped young men. Journal of Clinical Psychiatry, 47(5), 234-237.

National Clearing House for Alcohol and Drug Information. (1987). NCADI Update: Alcohol and other drugs and the physically/mentally impaired. Rockville, MD.

National Institute on Alcohol Abuse and Alcoholism. (1980/81, Winter). Alcohol Health and Research World, 5(2). U.S. Department of Health and Human Services.

National Institute on Drug Abuse. (1985). Vol. 4, #2. Rockville, MD: U.S. Department of Health and Human Services.

NIAAA, Alcohol and Health - Sixth Special Report to U.S. Congress. (1986). Rockville, MD: U.S. Department of Health and Human Services.

O'DonnelL, J. J., Cooper, J. E., Gessner, J. E., Shehan, I., & Ashley, J. (1981/82). Alcohol, drugs and spinal cord injury. Alcohol Health and Research World, 6(2), 27-29.

Peterson, J., & Nel:povich, M. (1983). Alcoholism and the visually impaired client. Journal of Visual Impairment and Blindness, 77(7), 345-347.

Rasmussen, G. A., & DeBoer, R. P. (1980/81). Alcohol and drug use among clients at a residential vocational rehabilitation facility. Alcohol Health and Research World, 5(2), 48-56.

Rehabilitation Brief, Vol. V, #6. National Institute of Handicap Research, Office of Special Education and Rehabilitation Services, Department of Education. Washington, DC.

Reichler, B. D., Clement, J. L., & Dunner, D. L. (1983). Chart review of alcohol problems in adolescent psychiatric patients in an emergency room. Journal of Clinical Psychiatry, 44, 338-339.

Rimel, R. W., & Jane, J. A. (1983). Characteristics of the head-injured patient. In M. Rosenthal, E. R. Griffith, M. R. Bond, & J. D. Miller, Rehabilitation of the head injured adult (pp. 9-21).

Sabin, M. C. (1988). Responses of deaf high school students to an "Attitudes Toward Alcohol" scale: A national survey. American Annals of the Deaf, 133(3), 199-203.

Schaschl, S., & Straw, D. (1988). Chemical dependency: The avoided issue for physically disabled persons. Unpublished paper, Sister Kinney Institute. Abbott-Northwest Hospital, Minneapolis, MN.

Sengstock, W. L., Vergason, G. A., & Sullivan, M. M. (1975). Considerations and issues in a drug abuse program for the mentally retarded. Education and Training of the Mentally Retarded, 10, 138-143.

Skinner, H. A., Holt, S., Schuller, R., Roy, J., & Israel, Y. (1984). Identification of alcohol abuse using laboratory tests and a history of trauma. Annals of Internal Medicine, 101, 847-851.

Spicer, J. (1989). Counseling Ethnic Minorities. Hazelden Educational Materials. Pleasant Valley Road, Box 196, Center City, MN, 55012-0176.

Steitler, K. (1984). Substance abuse and the deaf adolescent. In G. Anderson & D. Watson (Eds.), The Habilitation and Rehabilitation of Deaf Adolescents. Wagoner, AK: University of Arkansas Rehabilitation Research and Training Center on Deafness and Hearing Impairment.

Sylvester, R. A. (1986). Treatment of the deaf alcoholic: A review. Alcoholism Treatment Quarterly, 3(4), 1-23.

Thurer, S., & Rogers, E. S. (1984). The mental health needs of physically disabled persons: Their perspectives. Rehabilitation Psychology, 29(4), 239-249.

Tobis, J. S., Puri, K. B., & Sheridan, J. (1982). Rehabilitation of the severely brain injured patient. Scandinavian Journal of Rehabilitation Medicine, 14.

Tremble et al., (1983). Paper cited in Preventional and Ethnicity: Current Research. Florida Alcohol and Drug Abuse Association.

U.S. Bureau of the Census. (1987). Statistical Abstract of the United States - 1988. 108th edition. Washington, DC: U.S. Bureau of the Census, Table 174, pp. 108.

Weissman, M., Myers, J., & Harding, P. (1980). Prevalence and psychiatric heterogeneity of alcoholism in the U.S. urban community. Journal of Studies of Alcohol, 41, 672-681.

Wentzel, C. (1986). An outline for working with the hearing impaired in an inpatient substance abuse treatment program. AIOD Bulletin, 8(1), 1-6.

Westermeyer, J., Phaobtong, T., & Neider, J. (1988). Substance use and abuse among mentally retarded persons: A comparison of patients and a survey population. American Journal of Drug and Alcohol Abuse, 14(1), 109-123.

Chapter II

MEDICAL ASPECTS OF SUBSTANCE ABUSE

This chapter is intended to familiarize the reader with some of the basic medical aspects of substance abuse. It is assumed that the reader is already familiar with the physical, mental, and emotional disabilities that may coexist with substance abuse. Consequently, the medical aspects of those conditions will not be covered. The chapter includes an overview of substances; classification of substances; the nature of addiction and its effects on the individual; the pharmacology of substances; the interaction of such substances with commonly encountered physical, mental, and emotional disabilities; and theories of substance abuse as a genetic predisposition.

The specific substances covered include drugs that are most often abused: alcohol, hallucinogenic drugs, marijuana, nicotine, opiates, sedatives, stimulates, and inhalants (Wright, 1980). Cocaine has become a major substance of abuse in the last decade and will also be covered. In addition to reviewing the pharmacological factors associated with each drug, the chemical names of the drugs, the common or street names (see Appendix B), the source and/or forms of the drug, effects, tolerance, dependence, and the withdrawal/abstinence syndromes will be included.

CLASSIFICATION OF SUBSTANCES

There are many different methods of classifying substances abused by people. The classification presented in the following section is one of the most common ways found in many textbooks on the subject. These classification systems are presented to enhance the reader's awareness of classification systems and terminology.

Licit Versus Illicit

This method classifies substances by whether or not they are legal to prescribe and/or purchase. Common licit (legal) drugs would be alcohol, nicotine, caffeine, and prescribed medication obtained for legitimate medical purposes. Illicit (illegal) drugs would be most substances obtained through illegal channels including cocaine (crack), heroin, marijuana, LSD, PCP, and prescription medications sold "on the street" by unqualified persons.

Mood Altering Versus Non-mood Altering

This method classifies substances into two categories: those which affect the Central Nervous System (CNS) and those that do not have such effects. Common mood altering

substances are sedatives, antidepressants, tranquilizers, pain killers, and psychotropic drugs used in the treatment of mental illness such as lithium, mellaril, thorazine, etc. Non-mood altering drugs are those used for other medical purposes and which do not have CNS effects, such as antibiotics, vitamins, and those medications used for the regulation of blood pressure.

Medical Versus Non-medical Substances

This system classifies drugs by whether or not they are prescribed and used for legitimate medical purposes or whether they are used for experimental or "recreational" purposes. Examples of medical substances are antipsychotic, tranquilizers, and pain killers prescribed by a physician for a specific medical purpose. Examples of non-medical (recreational) drugs are prescription drugs obtained through illicit means, alcohol, marijuana, LSD, and cocaine obtained and used for non-medical purposes as well as other similar drugs.

Uppers Versus Downers

This classification system relates to drugs which normally affect the CNS in two opposing manners. Uppers generally stimulate the CNS, while downers refer to drugs which generally have a depressant effect on the CNS. Familiar uppers would be cocaine (crack), diet pills, nicotine, and caffeine. Common downers are alcohol, sedatives, tranquilizers, and pain killers. This classification system creates difficulty in classifying marijuana and hallucinogens.

THE NATURE OF ADDICTION

Major Effects of Substances on the Central Nervous System

Common to all drugs that are abused is the effect they have on the central nervous system. This effect most often occurs at the neuro-neural (synaptic) junction in the brain where they block neurotransmitters. The result of this blocking produces pathological effects at the tissue level, as well as in psychological or social functioning. The alteration of neuron function by influencing a receptor site between two neurons results in an S-shaped dose response. Low doses of the drug are accompanied initially by a slow appearance of drug effect which increases rapidly with intermediate doses followed by a gradual leveling off of drug effect with high doses (Westermeyer, 1986).

Addiction Defined

Addiction is a widely, almost over-used term, for compulsive use of a substance. One closely related concept is dependence. The Diagnostic and Statistical Manual of Mental Disorders III-R (DSM III-R) (1987), the psychiatric classification manual used by the American Psychiatric Association, contains no reference to addiction, only dependence. On the other hand, Liska (1986) defines addiction as:

> A drug-induced change in the physical state of an individual, such that he/she required the continued presence of the drug to function normally. Further, upon abrupt termination of the drug, the addict would suffer through a physical crisis,

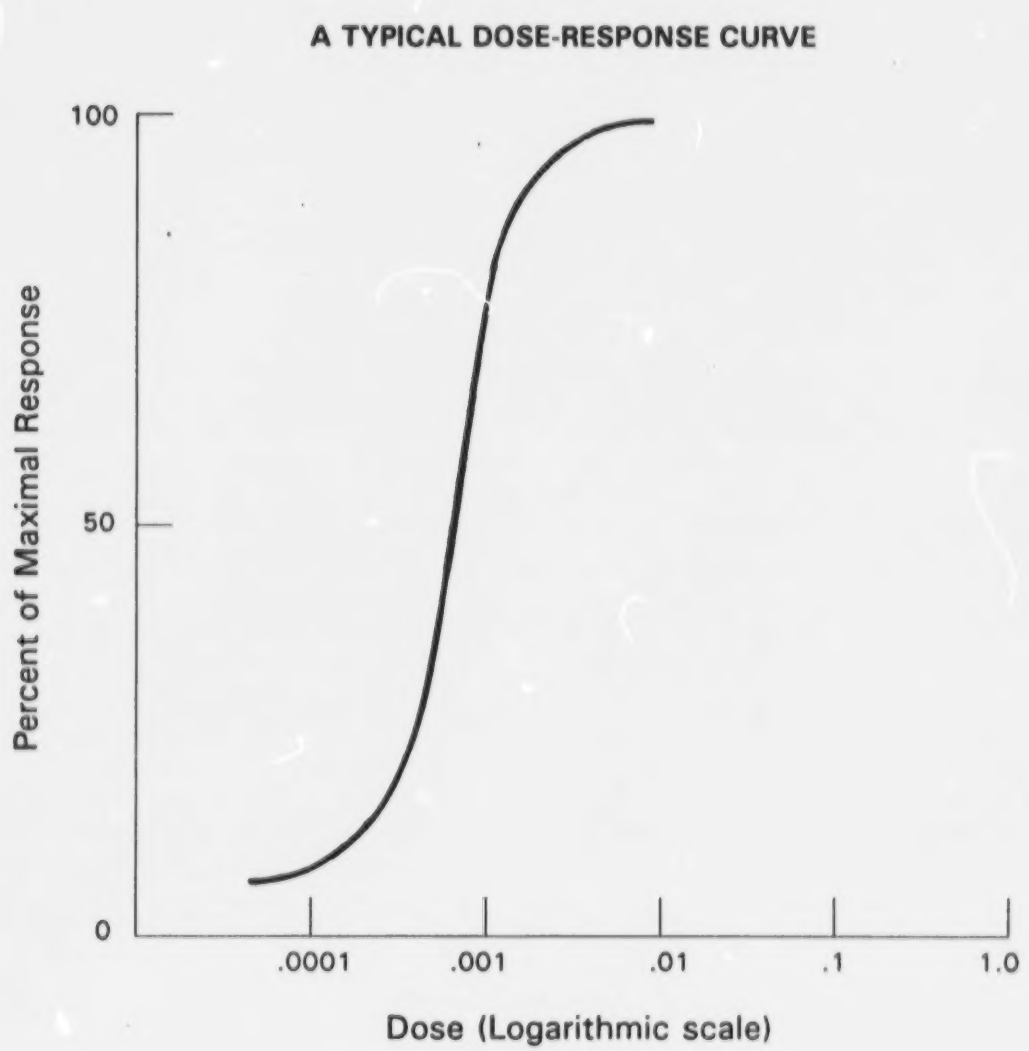

Figure II-1

> of varying degree, known as withdrawal syndrome (also termed abstinence syndrome). The withdrawal crisis could be ended at any time by readministering the drug. (p. 7)

Liska (1986) and White (1991) suggest that since many drugs used by persons today do not result in physical dependence as described above, **addiction** as a concept is not used as often as **dependence**. White (1991) states "...the words 'addicted' and 'dependence' will be used synonymously" (p. 7). The American Psychiatric Association's DSM III-R (1987) makes the following explanation of why physical withdrawal (always a distinguishing aspect of addiction) was dropped as a criterion for dependence (addiction):

> The symptoms of the dependence syndrome include, but are not limited to, the physiological symptoms of tolerance and withdrawal (as in DSM-III). Some people with physiological tolerance and withdrawal may not have the dependence syndrome as defined here. For example, many surgical patients develop a tolerance without showing any signs of impaired control. Conversely, other people may show signs of severely impaired control of psychoactive substance use (e.g., cannabis) without clear signs of physiological tolerance or withdrawal. (p. 166).

In addition to physical dependence, a psychological dependence may develop with chronic substance use that is perhaps even more powerful in terms of its effect than physical dependence. Feelings of insecurity, the need to belong, the striving for perfection, the need for power, etc., are expressed as reasons for use by the individuals who abuse substances. They believe these substances enhance their ability to deal with boredom, provide pleasure, and/or eliminate frustration. The mood altering characteristics of these substances create a powerful drive to continue the use of the substances. Cessation of substance use creates psychological withdrawal symptoms if the individual does not find more appropriate ways to fulfill these needs.

Therefore, for the purpose of this chapter, dependence and addiction will be used interchangeably. Despite this terminological quagmire, two characteristics of habitual substance abuse found throughout the literature are **chronicity** and **progression** (O'Brien & Chafetz, 1982). Chronicity relates to the concept that once an individual is dependent, such an individual is never **cured**, but the problem remains with the individual throughout his/her lifetime. Dependency may be arrested through the affected individual's remaining abstinence, but if she/he ceases abstinence, all the problems accompanying dependency will return. Progression relates to the concept that once dependence has developed, the effects of the dependence become increasingly worse. For example, even when abstinent the addicted person is at risk for relapse if healthy coping strategies have not developed.

VIEWS OF ADDICTION

Throughout the literature on substance abuse, one will encounter several philosophies and/or views of addiction. Such views and philosophies offer widely disparate attributions for the "why's" of addiction. Lewis, Dana, and Blevins (1988) summarize these views as follows:

1. **The moral model**. People are responsible for creating and for solving their problems;

2. **The medical model**. People are responsible neither for their problems nor for the solutions;

3. **The enlightened model**. People are responsible for creating their problems but not for solving them; and

4. **The compensatory model**. People are not responsible for creating their problems but are responsible for solving them. (p. 15)

In terms of clinical practices, however, these views result in three approaches to treatment:

Medical model. First, there is the medical approach which views addiction as genetically transmitted and progressive in nature. This perspective holds fast to several major tenets, among which are: (a) a drug is a drug is a drug; (b) once addicted, always addicted, and (c) once addicted, progression occurs even during periods of abstinence. This is in general the view held by the Alcoholics Anonymous movement.

Learned phenomenon. A second view holds that addiction is a learned phenomena and what is learned can be unlearned. This view does not hold the same fatalistic view of the medical model. Typical advocates of this view are Peele (1988; 1989) and Fingerette (1988). Supporters of the "learned behavior" model often point to "experimental studies" such as the now infamous Sobel and Sobel study in support of this view. Behavioral theories of chemical dependency focus on the effects of stimulus events, reinforcement, and punishment (George, 1990).

Cognitive-behavioral approach. A third approach to treatment of substance abuse which has come to gain more adherents in the social science field is the cognitive-behavioral approach (Emrick & Aarons, 1990). The cognitive-behavioral theory postulates that substance abuse is a function of behavioral, social, and cognitive factors. This theory employs the examination of stimulus events in much the same manner as learning theories. A critical difference lies in the role of cognitive factors in the mediation of behavioral response to stimulus and social events. Cognitive-behavioral approaches emphasize that the "... choice of if, when, where, and how much to drink (or use) is strongly influenced by a person's interpretation of a given situational complex" (p. 9).

Tolerance

When a substance is used repeatedly and the effect of the substance plateaus or decreases, tolerance is said to have been reached. In other words, larger doses of the substance are needed to obtain the same or an increased effect.

To understand this phenomenon, one must be aware of the half-life of a substance. Half-life refers to the time it takes for a substance to decrease in its concentration in the body by 50%. A substance that is taken in intervals that are less than the half-life of the substance will accumulate in the body (Arif & Westermeyer, 1988). The shorter the half-life of the substance, the sooner it will be excreted and the greater will be the need for another dose to obtain the desired effects. However, when a residual of the substance builds up in the body (additional doses are taken before the half-life of the substance is reached), larger doses will also be needed to overcome the tolerance that the body has built up to the substance.

Cross Tolerance

Liska (1986) defines cross tolerance as "... a psychophysical state where one drug can prevent the withdrawal syndrome associated with a related but different drug" (p. 407). A very

common example is the prevention of "DT's" from alcohol withdrawal by taking diazepam (valium).

Cross tolerance occurs when there is a diminished tolerance to one drug brought on by the overuse of another, similar substance. In the realm of treatment, this phenomenon translates into the phrase, "a drug is a drug is a drug." Professionals in the alcohol and drug treatment field are most concerned about their clients substituting one drug for another. Applying the concept of cross tolerance, if a client substitutes valium for alcohol, (s)he will soon be using a comparable dosage of the drug to the equivalent amount of alcohol.

Another example of cross tolerance is what some treatment professionals refer to as the "P-A-C man" syndrome. It has been observed that many individuals, specifically males, entering treatment for cocaine abuse have histories which also include abuse of alcohol and pot (marijuana). Such persons begin their drug use histories by abusing pot, the **P** in the PAC man syndrome. They then begin to abuse alcohol, the **A** in the PAC man syndrome before moving on to cocaine (**C**). Once such an individual is treated and "clean" in regard to cocaine, some of them feel it is alright to return to the use of pot. Their use of pot leads, supposedly, to the abuse of alcohol which, in turn, leads them back to using cocaine.

THE PHARMACOLOGY OF SUBSTANCES

Alcohol

Ethyl alcohol or Ethanol CH_3 CH_2 (hereafter called simply alcohol) is the excrement of yeast. It is a fungus with a ravenous appetite for sweets. The process of fermentation occurs when it encounters fruits high in sugar and an enzyme is released which converts sugar to carbon dioxide (CO_2) and alcohol. Milam & Ketcham (1981) describe the sequelae as follows: "The yeast then continues to feed on the sugar until it literally dies of acute alcohol intoxication. Yeast may be, then, the very first victim of 'drunkenness'" (p. 17).

The percentage of alcohol differs with the particular type of beverage. In beer it could be between 3% and 6%. Distilled liquors are usually expressed in degrees of proof instead of percentage of alcohol. Proof is about double the percentage of pure alcohol. Therefore, 100 proof whiskey is 50% pure alcohol.

Alcohol is absorbed in small amounts from the mouth and esophagus, in larger amounts from the stomach and large bowel. The primary site of absorption, however, is the small intestine. The rate of absorption varies depending upon gastric emptying; the absence of absorption-interfering proteins, fats, and carbohydrates; dilution of alcohol; and carbonation (Shuckit, 1983).

After introduction into the blood stream, alcohol enters the various organs of the body. The brain usually tends to have a larger concentration due to its large blood supply. Alcohol may be detected in the blood within five minutes after intake with maximum concentration attained in 30 to 90 minutes (Victor & Adams, 1983). Distilled spirits are absorbed more quickly than wine and beer. Blood alcohol level (BAL) is a measure of the concentration of

alcohol in the blood. It is the BAL rather than the amount consumed which results in behavioral changes. Metabolism of alcohol begins in the stomach and continues in the liver with oxidation of alcohol to acetaldehyde, then to acetic acid, and finally to carbon dioxide and water.

There is a scale relating various degrees of clinical intoxication to blood alcohol levels in nonhabituated persons (Miles, 1972, Figure II-2). A blood alcohol level (BAL) of 30 milligrams per 100 milliliters (.03%) produces mild euphoria while 50 milligrams per 100 milliliters (.05%) may result in mild incoordination. Ataxia becomes evident at 100 milligrams (.100%) per 100 milliliters. This level is equivalent to 12 ounces of beer, 4 ounces of fortified wine, or 1.5 ounces (a shot) of 80 proof spirits. At 200 milligrams per 100 milliliters, the person is sleepy and may be confused. Stupor may be evident at 300 milligrams per 100 milliliters, while a level of 400 milligrams per 100 milliliters is accompanied by deep anesthesia and may prove fatal. For a chronic alcoholic, the BAL scale has little relevance due to the long term adaptive changes such as the development of tolerance and accelerated rate of metabolism of alcohol by the liver.

BLOOD ALCOHOL LEVEL SCALE*

Blood Alcohol Concentration	Effects
0.03% or 30 mgs. per 100 ml.	Mild euphoria
0.05% or 50 mgs. per 100 ml.	Mild incoordination/reactions slow
0.10% or 100 mgs. per 100 ml. equivalent to 12 oz. beer 4 oz. of fortified wine 1.5 oz. (a shot of 80 proof spirits	Ataxia evident Intoxification Slurred speech
0.20% or 200 mgs. per 100 ml.	Confusion to somnolence
0.30% or 300 mgs. per 100 ml.	Stupor
0.40% or 40 mgs. per 100 ml.	Deep anesthesia and may prove fatal

*For a chronic alcoholic, the BAL scale has little relevance due to the long term adaptive changes such as the development of tolerance and accelerated rate of metabolism of alcohol by the liver.

Figure II-2

Tolerance is a term which applies to all drinkers. An individual can develop the ability to drink large amounts of alcohol in the course of weeks or years. Some alcoholics experience a subtle increase in their drinking patterns, but most experience a more immediate change in their tolerance levels and can drink more than others and show less impairment soon after they first start drinking.

There are two major misconceptions about the phenomenon of tolerance which require clarification. Tolerance is not a learned response, contrary to common belief. Similarly, it is not within the alcoholic's conscious control or will. Physiological changes in the central nervous system and liver result in the appearance of tolerance. Central nervous system effects include changes in the brain electrical impulses, its hormones, its enzyme levels, and the chemical structure of the cell membranes. These changes cannot be explained by learned behavior.

The second misconception is that the person's excessive drinking results in the development of tolerance. The previously existing psychological and emotional problems are more likely the underlying cause of alcoholism. In attempting to escape from the stresses of life, the alcoholic begins to use alcohol as a coping mechanism and as tolerance expands, his/her intake is increased. Tolerance appears to be responsible for the alcoholic's continued use of increasingly larger amounts of alcohol. One of the first warning signals of impending alcoholism is an increase in the amount and frequency of drinking.

Once the central nervous system has adapted to chronic alcohol exposure, several weeks or more of abstinence is required to return the system to normal. The neurons have come to require alcohol for normal functioning. This results in physical dependence (Jaffe, 1980).

Withdrawal symptoms appear within 12 to 72 hours after total cessation of drinking alcohol. A mild reduction in drinking habits may be enough to produce the withdrawal symptoms. Victor and Adams (1983) identified three stages of withdrawal: mild tremor, alcohol related seizures, and delirium tremens (DT's). With minimal dependence, the withdrawal symptoms may consist of disturbed sleep, nausea, weakness, anxiety, and tremulousness. Withdrawal seizures (rum fits) begin within 7 to 48 hours after cessation, with the peak occurrence between 13 to 24 hours. Seizures could be grand mal (clonic-tonic) and could develop into status epilepticus (continuous seizures). Seizures usually precede delirium tremens (DT's) which is the most serious and dramatic form of alcohol withdrawal. Profound confusion, agitation, tremors, delusions, hallucinations, and sleeplessness characterize this syndrome. Persons experiencing such withdrawal usually have a rapid pulse, fever, and profuse sweating. Approximately 5% of DT cases can end fatally.

Treatment, in delirium tremens, must include a thorough physical examination to search for associated injuries, particularly subdural hematoma, infections, gastrointestinal, and liver problems. Correction of fluid and electrolyte losses and nutritional replacement therapy, when needed, must be provided. Withdrawal symptoms usually respond to sedatives but, if used, these should be gradually withdrawn and eventually stopped. The purpose of this medication is to allow the person to rest and reduce agitation.

Hallucinogens

As one might expect, the common factor among the drugs that are classified as hallucinogens is that they all produce perceptual and cognitive changes. These drugs include lysergic acid diethyalmide (LSD, acid), indolylalkylamines (psilocybin), phenylalkylamine derivatives such as mescaline and peyote, and phencyclidine (PCP, angel dust). Of these drugs LSD and PCP are the most prominent.

LSD reached its popularity during the late 1960s and produces perceptual and cognitive changes including delusions, hallucinations, and psychosis. It is most often ingested orally and produces an effect in 30 to 40 minutes. The effects may result in somatic, perceptual, and psychic symptoms. Somatically, such symptoms as dizziness, weakness, tremors, nausea, and drowsiness may be experienced. In terms of perceptual effects, the user may experience alterations in shapes and colors (psychedelic) and difficulty in concentration. Psychically, lability in mood, disorientation in time relationships, depersonalization, paranoid ideation, and hallucinations may occur. While there are few physiological changes, somatic and perceptual changes occur before psychic defects. The latter may last up to 12 hours after only a single dose. While a significant degree of tolerance develops to LSD after only a few doses, withdrawal effects do not occur and responsiveness on the part of the user returns rapidly after a relatively brief drug-free interval.

PCP, or "angel dust" as it is frequently called on the street, was originally used by veterinarians as a general anesthetic. It is very easy to produce in a simple laboratory and is ingested by injection, smoking, or snorting. Its effects are numerous and varied. Neurologically, the user often experiences motor incoordination, labored speech, shakiness, increased muscle tension, and heightened reflexes. One's blood pressure, systolic as well as diastolic, is often elevated. However, heart activity is often decreased. While lower doses are usually followed by euphoria, those periods of exaggerated well-being are often followed by heightened anxiety, unexplained and frequent mood changes, and hostility. Homicide has even occurred following use in unusual cases. The effect of PCP has often been referred to as being similar to states of sensory deprivation. Higher doses may cause muscular jerks, continuous seizures, coma, and psychosis. In some cases, an analgesic or anesthetic effect may lead to an indifferent reaction to painful stimuli resulting in self-injury. Tolerance to the drug has been demonstrated in animal experiments and some human users may abuse the drug daily, unlike most of the other hallucinogens.

Indolylalkylamines such as psilocybin are found in mushrooms and has only 1% of the potency of LSD. Phenylalkylamine derivatives such as mescaline and peyote, found in Mexican cactus, are approximately 1/1000 as potent as LSD. The latter is consumed legally in Native American Indian religious rituals (Arif & Westermeyer, 1988; Westermeyer, 1986).

Cannabis

Cannabis comes from the resinous substances of the plant Cannabis sativa L., which contains psychoactive and intoxicating ingredients. Although beverages, soups, cakes, and other foods can be used, the most popular method of ingestion is by smoking the dried flower tops and leaves as marijuana (pot) or hashish (a more potent form of the drug). The psychoactive effects

of the drug are primarily due to delt-9-tetrahydrocannabional (THC). Although ingesting the drug through smoking results in only half of the available THC reaching the lungs, effects occur rapidly after inhalation, and the effect of one marijuana cigarette lasts for about three hours.

While most smokers of marijuana and hashish seek relaxation and a sense of well-being from using the drug, THC produces changes in mood, sense of time, memory, and brain functions. Short-term memory is impaired. Coordination, balance, and stance is interfered with, although simple motor tasks are not initially impaired. Concentration and the ability to converse meaningfully are inhibited. Minutes may seem like hours with silliness and laughter prevalent. Acute effects include a dry mouth and throat, increased hunger, and tachycardia. Higher doses and chronic use may result in severe cognitive brain impairment, thought disruptions, hallucinations, delusions, mood changes, paranoia, and diminished testosterone levels. The tar produced by marijuana smoke, as is the case with tobacco smoke, is carcinogenic and a chronic cough is reported by chronic users.

Physical dependence on THC does occur in humans. Storage of THC in fatty tissues results in a physiologic dependence which may last from several days to several weeks following cessation of use. Tolerance to some cannabionoid effects has been found in animals and humans. Withdrawal leads to adaptational decrease in heart rate, increase in skin temperature, and pressure within the eyes (Arif & Westermeyer, 1988; Westermeyer, 1986).

Opioids/Opiates

Opiates are obtained from the poppy and include morphine, codeine, and thebaine. Semi-synthetic opiates, produced by chemical manipulation of these phenanthrene alkaloids of opium, include heroin (horse) and oxycodone. Opioids which are entirely synthetic (produced in the laboratory) include methadone, meperidine (demoral), fentanyl, and propoxyphene (darvon). The preferred method of ingestion is usually by intravenous injection.

All of the opioids have the beneficial effect of relieving pain, insomnia, anxiety, cough, visceral changes, and diarrhea. This occurs in part because opioids affect the central nervous system by suppression of the cough reflex and interfering with pain perception. Larger doses may have even more untoward effects including shallow breathing, decreased blood pressure increasing the release of antidiuretic hormone, and diminished sexual interest.

Tolerance often develops with the first dose. While the user initially seeks the effect of the drug itself, eventually relief from withdrawal symptoms produced by increasing tolerance is also an important aspect of drug abuse. When the person who has developed dependence on one of the opioids stops taking the drug, withdrawal symptoms may occur within 4 to 24 hours. The symptoms worsen from 24 to 72 hours with acute symptoms ending within 4 to 10 days. Although the ordinary dose of morphine is 15 to 30 milligrams, highly tolerant users of opioids may take up to 1000 milligrams. This and the severity of withdrawal symptoms may lead to repeated detoxification in order to obtain the same effect from lower doses of the drug (Arif & Westermeyer, 1988; Westermeyer, 1986).

Cocaine

Cocaine (coke, snow, crack) is extracted from the coca leaf in the form of active alkaloid. Its local anesthetic properties led to it being sold as a legal ingredient in wine, tonics, and soft drinks until the early twentieth century. One common form of cocaine is hydrochloride which is white crystalline powder, formed by processing coca paste, usually consumed by snorting. In recent years, smoking the alkaloid itself (free base or crack cocaine) has become popular. It requires mixing the white powder with baking soda until a hard, yellow crystal is formed known as crack or a rock, consumed by smoking in a water pipe. The result is the user experiencing an immediate, intense feeling of euphoria and well-being. However, its effect is brief, lasting only a few minutes, and the process has led to many severe burns.

Cocaine stimulates the central nervous system, producing euphoria, alertness, increased self-esteem, disinhibition, relief from fatigue, and psychomotor excitement. The euphoric effect disappears quite rapidly, and larger doses of the drug may result in marked agitation, insomnia, loss of appetite, convulsions, paranoia, and acute psychosis. Physical consequences of chronic cocaine use may include constriction of the blood vessels; degeneration of the inner wall of the nose; pulmonary problems; blood problems; rapid, but disorganized heart beat; and a variety of infections. Crack users may experience severe depression and suicidal ideation following cessation of use.

Cocaine dependence has been recognized by the World Health Organization as the most reinforcing and thus potentially addicting drug known for many users. Animals, as well as humans, become compulsive users and both may pursue the use of cocaine until death. Cocaine dependent humans often prefer cocaine intoxication to all other activities. This often results in their engaging in acts that were previously thought to be unacceptable. As mentioned earlier, cessation of cocaine use leads to withdrawal characterized by severe depression. This may lead to self-treatment with cocaine to relieve the depression. While the depression is often not relieved, compulsive cocaine use reoccurs. Consequently, relapse is a high risk for cocaine users (Arif & Westermeyer, 1988; Westermeyer, 1986; & Benshoff & Riggar, 1990).

Sedatives

This broad category of drugs also includes hypnotics and anxiolytics in addition to sedatives which are usually prescribed for medical purposes but can also be obtained by illegal means. Specific drugs include barbiturates, benszodiazepines, ethchlorvynol, glutethimide, methaqualone, meprobamate, chloral hydrate, and paraldehyde. The common thread found among these drugs is that they all tend to alleviate anxiety and induce sleep.

Barbiturates (downers, bluebirds) are derivatives of malonylurea and can be either short acting or long acting in their effect on the user. Short acting barbiturates are preferred by drug abusers although longer acting barbiturates (e.g., phenobarbital) may be less problematic during withdrawal. Blutethimide has a longer duration of effect which often results in fatal overdoses. Ethcholorvynol is shorter acting and has some therapeutic properties while methaqualone is popular among sedative abusers because of its reduced cardiovascular and respiratory depression. Chloral hydrate and meprobamate resemble barbiturates in relation to sedation tolerance and dependence. Benzodiazepines have been utilized medically since the 1960s for their antianxiety,

sedative, anticonvulsant, and muscle relaxing properties. However, abuse of this drug can lead to tolerance, dependence, dose escalation, and withdrawal symptoms.

The major effects, physiologically, of this class of drugs is to inhibit or impair transmission of nervous impulses and increase the onset and duration of sleep. Suppression of rapid eye movement (REM) sleep often results in excessive dreaming, sometimes with vivid nightmares. Suppression of the central nervous system can be so complete as to cause respiratory cessation and death. Cardiovascular function may also be suppressed, and these agents are often used by persons who wish to commit suicide.

The therapeutic effect of these drugs tends to be short, and tolerance can develop with a single dose. Consequently, the chronic user needs ever larger doses to achieve the effect desired. Motor incoordination, labored speech, and slowness in thought as well as movement may result. Withdrawal symptoms can include delirium tremens, convulsions, tachycardia, and hallucinations or delusions (Arif & Westermeyer, 1988; Westermeyer, 1986).

Amphetamines

Amphetamine drugs (uppers, speed) may be taken orally or injected intravenously. By either method they stimulate the central nervous system, producing increases in several aspects of the body's rates or functions. They have been popular ingredients in diet pills for many years and, as with all substances that are abused, cause untoward effects physically as well as behaviorally.

The effect of amphetamines on the central nervous system often results in increases in systolic and diastolic blood pressure, increases in pulse pressure, and, with large doses, result in rapid and/or rapid but irregular heartbeat. They increase the metabolic rate, relax bronchial muscles, and increase temperature. Behaviorally, amphetamines result in increased alertness and wakefulness, elevated mood accompanied by increased self-confidence, and an increase in psychomotor activity to the point where performance of tasks may be improved. There is also a lessening of the need for rest and sleep with decreased fatigue and reduced appetite.

Tolerance to amphetamines occurs in relation to its anorexiant effect, mood elevation, and euphoric effects. Both physical and psychological dependence occurs with varied withdrawal effects upon abstinence. While these effects vary considerably with the individual, they may include profound fatigue, lack of energy, depression, nervousness, agitation, tremor, insomnia, confusion, delirium or panic states, and paranoid ideation. Two types of psychosis may result: toxic psychosis which improves within a few days of termination of drug use; and psychosis with schizophreniform, affective, or paranoid features. The latter tends to persist beyond intoxication and resists improvement with supportive treatment alone. Consequently, individuals with a diagnosis or history of schizophrenia are very sensitive to even small doses of amphetamines (Arif & Westermeyer, 1988; Westermeyer, 1986).

Tobacco/Nicotine

Although tobacco is certainly not an illegal drug, nicotine, the primary psychoactive compound in tobacco and its many other active ingredients, can result in untoward effects on

the body. Consequently it is appropriate to discuss it in this chapter on the medical aspects of substance abuse.

Tobacco and tobacco products may be ingested by chewing, sniffing, or smoking. Because of its toxic effect, nicotine is occasionally used as a pesticide and can be fatal to a small child who eats one cigarette containing 20 milligrams of nicotine. Its initial effect--a stimulant. However, its later effects are just the opposite--a depressant. Small doses of nicotine appear to stimulate the autonomic nervous system and muscles. Larger doses inhibit or paralyze the autonomic ganglia and neuromuscular synaptic sites. Nicotine also stimulates the central nervous system and large doses taken orally may result in convulsions. Peripheral effects of the drug inhibit gastric contractions, slow down gastrointestinal emptying, and increase the heart rate. Consequently, it has been observed to improve cognition and memory, decrease aggression, and decrease body weight.

Tolerance develops because of the depressant effects of nicotine after a few doses. This results in dependence physically on the drug. However, psychological dependence also occurs in relation to the social situations in which it is used, e.g. relaxing after a meal, dealing with the stress of making new acquaintances, taking a break during working hours, etc. The withdrawal syndrome includes a craving for tobacco, restlessness, headaches, and impairment of concentration (Arif & Westermeyer, 1988; Westermeyer, 1986).

Caffeine

Another very common drug used and potentially abused by a large part of the population is caffeine. Occurring in a variety of plants, alkaloid caffeine is most often found in coffee, cola beverages, tea, and other substances such as tablets that are part of analgesic preparations, stimulants, anorexiants, etc. Cola contains 45 to 55 milligrams per 12-ounce serving and ground coffee 80 to 180 milligrams per 5-ounce serving. Interestingly, decaffeinated coffee contains 3 milligrams of caffeine per 5-ounce serving.

Most often consumed orally, the effects of caffeine include diminishment of drowsiness and fatigue, enhancement of mental abilities for some tasks, tachycardia, increased force of cardiac contraction, increase in gastric acidity secretions, a relaxation of smooth muscle, and a diuretic effect. Larger doses may result in increased excitement, anxiety, and insomnia.

While tolerance to caffeine may develop to a mild extent in individuals who consume small quantities daily, dependence, as well as tolerance, occurs in individuals who consume high doses (600 milligrams or more) each day. Abstinence results in headaches, irritability, restlessness, lethargy, and excessive yawning. Individuals who consume high doses of caffeine can experience a syndrome characterized by headaches, irritability, agitation, anxiety, trembling, and insomnia whether the user is intoxicated or in withdrawal (Arif & Westermeyer, 1988; Westermeyer, 1986).

Volatile Solvents-Inhalants

There are a number of substances around the home and the work place that contain psychoactive chemicals which, when inhaled as gases or vapors, result in intoxication. These

substances include aromatic hydrocarbons found in benzene from coal and petroleum; aliphatic hydrocarbons or paraffins; amyl nitrites in the form of smelling salts in crushable glass ampules; halogenated solvents and propellants found in freon; tircholorianted solvents and chloroform, found in cleaning solvents and degreasers; and inhalational anesthetic drugs such as ether and nitrous oxide.

The effects of these solvents and inhalants are similar to alcohol in terms of their intoxication and resulting central nervous system depression accompanied by euphoria and disinhibition. However, the potential untoward effects of these substances far outweigh the momentary highs they produce with repeated use. These may include cardiac arrhythmias leading to death; chronic nervous system damage in the cerebral cortex, cerebellum, spinal cord, and peripheral nerves; liver disease; kidney damage; hypertension; dizziness; and tachycardia. Amyl nitrites also have properties that delay ejaculation. As such, they are sometimes used to enhance sexual pleasure by delaying orgasm and can result in habituation as an adjunct to sexual activity. They are thought to contribute to the spread of acquired immune deficiency syndrome (AIDS) by lessening one's inhibition for casual sex and suppressing or damaging the immune system (Arif & Westermeyer, 1988; Westermeyer, 1986).

INTERACTION OF SUBSTANCES WITH OTHER PHYSICAL, MENTAL, AND EMOTIONAL DISABILITIES

The abuse of a vast number of prescribed and recreational substances and the complexity of the havoc that such abuse can wreak on the body complicates the habilitation/rehabilitation of persons with disabilities. Most of the substances that have the potential for abuse are used to relieve pain, allay anxiety, allow a person to sleep, alleviate fatigue, and have pleasurable effects. The various forms of use usually lead to patterns of increased frequency and/or amount of use and eventually to dependence or compulsion.

Some of the most frequently encountered disabilities in vocational rehabilitation will be presented in this section to provide the reader with basic information regarding medical management. These disabilities were selected because of their medical management problems.

Traumatic Brain Injury

The traumatic head injured person applying for vocational rehabilitation services generally does not require medications except to alleviate the residual functional effects of the injury. Post traumatic headache can be alleviated by aspirin or tylenol. Spasticity is also a frequently encountered symptom resulting from head injury. Commonly used drugs to improve functional capabilities are Dantrolene Sodium (Dantrium) and Baclofen. Both of these drugs produce drowsiness, dizziness and, generalized weakness, which are generally transient. When seizures are a residual effect of head injury, an appropriate anticonvulsant is often prescribed. Most commonly Diphenylhydantoin (Dilantin), Carbamazepine (Tegretol) and Phenobarbital, or a combination of these drugs is used. This group of medications can initially produce drowsiness, sluggishness, and dizziness. Regular monitoring of the blood level and effects of the drugs must be performed. There are other side effects of these drugs such as liver dysfunction, but their effects on the central nervous system are the most functionally disabling.

Spinal Cord Injury

Persons who sustain a complete spinal cord injury due to a fractured vertebrae suffer a permanently damaged spinal cord. Depending on the level of the injury (e.g., neck), pulmonary functions are compromised. Bowel and urinary bladder as well as genital functions are also affected. Bowel and bladder incontinence as well as uncontrolled genital erections or impotence usually occur in males. For females with a spinal cord injury, the genital system is minimally effected. They usually continue to have their normal monthly menstrual flow and hence can become pregnant. When the person has reached the maximum improvement in therapies, medications are not usually necessary other than to render the urine acidic by using oral bacteriostatic drugs to prevent frequent urinary tract infections. Bowel habits need to be regulated by eating a high fiber diet, the use of stool softeners, rectal stimulation, and/or suppositories to promote regular bowel elimination. Skin care is very important to prevent pressure sores. Maintenance of joint range of motion to prevent contracture and to improve spasticity are equally important. In instances when spasticity prevents the individual with a spinal cord injury from resting at night, the use of muscle relaxant drugs, such as Baclofen or Dantrolene Sodium (Dantrium) is indicated. In the sixties and seventies, the drug Diazepam was used frequently for spasticity. Due to its effect on the central nervous system and the high degree of its misuse or abuse, this drug is not currently routinely used.

Among persons with spinal cord injuries, complaints of burning pain and tingling sensations are commonly experienced. At times, these symptoms can become functionally disabling. The drugs of choice at these times are not narcotics but drugs affecting nerve tracts and neurotransmitters like Carbamazepines (Tegretol), Diphenylhydantoin (Dilantin), and antidepressants in the family of the Amitriptylines (Elavil), etc. Nonnarcotic analgesics can be added to the regimen, if needed. If complaints of pain persist, a complete diagnostic workup must be performed to search for the cause of the pain.

Attention to the psychosocial needs, allaying anxiety through education regarding bodily functions, and improving self-esteem and self-worth should be emphasized during treatment for persons with spinal cord injuries. Aiming for an organized life style including personal care attendants, accessible housing, linkage with social services, good medical supervision, involvement in worthwhile intellectual pursuits, and extensive counseling and support for family and/or significant others will not only improve the quality of life, but minimize the misuse and abuse of substances.

Neurological Disorders

Neuromuscular diseases include muscular dystrophy and its different types (e.g., Duchenne, Fascioscapulohumeral, Myotonia) and conditions like Fredericks Ataxia, etc. Persons with these disabilities do not require much in the way of medication. Skeletal complaints manifested as pain occur when the condition is complicated by scolioses with pressure symptoms and structural changes to the joints. It is of utmost importance that proper assistive devices be prescribed at the earliest stage to minimize musculoskeletal joint changes, preventing joint compression symptoms and resulting pain. Proper positioning, maintenance of joint ranges and nonsteroidal, anti-inflammatory analgesic drugs, if needed, are the treatments and medication of choice. Other drugs that may be needed are related to the cardiovascular and pulmonary

systems which do not have a potential for abuse.

Since the etiology of multiple sclerosis is still unknown, the line of medical management is mainly supportive to maintain activities of daily living. When the bowel is affected, high fiber diet and stool softeners are usually needed. For urinary bladder dysfunction, prevention of recurrent infections with the use of appropriate antibiotics is necessary. There are medications that are prescribed including the immunosuppressive drugs. While they may delay the progression of the disease, they are not curative.

Seizure Disorders

Seizure disorders are a symptom of an underlying disease(s) and/or a previous central nervous system insult. Seizures can frequently be triggered or caused by alcoholism. Treatment is directed to the suppression of the irritable focus in the brain to prevent the electrical discharge manifested as seizures. It is important for the patient to have adequate neurological workup for proper treatment as well as follow-up. Appropriate anticonvulsants are used for the type of seizure (tonic/clonic, psychomotor, etc.). In some cases, two or more different kinds of medications are necessary. The most frequently used drugs are Diphenylhydantoin (Dilantin), Carbamazepines (Tegretol), Phenobarbital, or Depakene. Other drugs may be used in combination with these drugs. The therapeutic goal is to minimize or prevent episodes of seizures so the person can function safely in all activities.

Developmental Disabilities

Persons who are developmentally disabled (mental retardation, attention deficit disorder, visual impairment, and hearing impairment) generally do not need medication. The exception is the person with an attention deficit disorder who frequently receives a central nervous system stimulant such as Ritalin or Cylert. These drugs have caused side effects and are currently being reassessed for their continued use.

Diabetes Mellitus

Diabetes mellitus is a disease with multiple causes, manifestations, and complications. Type I diabetes usually requires Insulin replacement therapy. Individuals with Type II diabetes mellitus are noninsulin dependent and usually are managed with oral hypoglycemics, weight reduction, and exercise. Other causes of diabetes mellitus include one seen among alcoholics due to acute pancreatitis. Among the multiple complications of diabetes are peripheral neuropathy, visual impairment, nephropathy, and cardiovascular effects. Therapy is directed to prevent further complications and to treat the complications that have occurred.

Psychiatric Disorders

Persons with psychiatric disorders are probably the most difficult group to manage medically. Close psychiatric and mental health supervision is required. Family participation and individual therapy is needed to effect stability. Persons with these disorders are frequently on antidepressants, or psychotropic drugs that alter mentation. Monitoring blood levels and effective dosage of the drug to control symptoms are important in treatment. Placement in

environments that are less stressful is often beneficial.

Chronic Pain

Chronic pain is seen as a condition that is enormously frustrating to health care practitioners. Pain is a symptom whose causes are legion in number. Oral narcotics such as Vicodin or Percocet (Oxycodone and Acetaminophen), Percodan (Oxycodone and aspirin), Propoxyphene (Darvon and aspirin), Meperidine (Demerol), and Morphine are frequently prescribed to treat this symptom. As a result, misuse and abuse often occur. In most cases, the effectiveness of the narcotic drug requires increasing the dosage to a point where undesirable effects, notably mental clouding, sedation, and gastrointestinal symptoms, are experienced. It should be noted that most narcotic-type analgesics do not completely erase the perception of pain, rather they change the affective interpretation of the painful experience (Inturrisi, 1990). Adjunctive agents can be administered orally and parenterally, e.g. nerve blocks, pulse-generating electrotherapy based on gate control theory, etc. (Turturro, MacLeod, Lorei, & Paris, 1990). Neurosurgical intervention is usually the last resort. In the presence of anxiety and/or depression, perception of pain is frequently altered, often causing the person experiencing the pain to feel the need to take more medication than is actually necessary.

A thorough history taking and diagnostic workup are necessary to identify organic from nonorganic causes that may suggest psychogenic problems. Identification and correction of anatomical, structural, and physiological problems must be carried out so appropriate management including physical, occupational, and other treatment modalities can be provided. Allowing the person with chronic pain to regain control over what is being experienced through education regarding bodily functions, reassurance, and close medical supervision is important. Psychosocial stresses including economic and relationship issues should be explored so an appropriate plan of action can be implemented which takes a comprehensive approach to improvement. The use of antidepressants and nonnarcotic analgesics will be adequate in the majority of chronic pain cases.

SUBSTANCE ABUSE AS A GENETIC PREDISPOSITION

There is evidence that certain individuals are predisposed, genetically, to problems of addiction. This evidence has arisen from two different fields of research--twin studies and chromosomal studies. In addition, the reader should be aware that there are some individuals who dispute the disease concept of alcoholism. The following briefly discusses these issues.

Twin Studies

Several studies are cited in the literature as pointing to a definite genetic influence in an individual's development of alcoholism (Shuckit, 1989; Collins & de Feibre, 1990). The most important and significant studies of this genetic influence come from Scandinavian countries who developed elaborate mechanisms for tracking adopted twins separated at birth. Most such studies indicated that children of alcoholic natural parents who grow up in nonalcoholic homes have a 3 to 4 times higher risk of becoming alcoholic than control groups. Some studies discussed by

Collins and de Feibre (1990) tend to indicate that genetics may be more important in younger rather than older persons with environmental factors having added significance.

Chromosomal Studies

Recent advances in research and the knowledge gained from this research is helping to change prevailing attitudes about alcoholism. Substantial scientific evidence during the past three decades has been accumulated citing that both genetic and environmental factors predispose the development of alcoholism in certain individuals. Evidence has been accumulated that indicates that alcoholism is a heterogeneous entity arising from multiple etiologies.

However, gene specific subtypes of alcoholism can be identified through using Restriction Fragment Length Polymorphism (RFLP) as a genetic tool. A DNA sequence is isolated that is closely associated and/or linked with a particular disease of interest. The goal is to identify one gene marker which is associated with the disease.

Blum et al. (1990) have reported the first allelic association of the human dopamine D2 receptor gene in alcoholism. The region q-22 to q-23 of chromosome 11 is suggested to be involved in the susceptibility to at least one form of alcoholism. This is a promising finding for the future.

Anti-addiction Theories

The disease model of substance abuse or chemical dependency is the most widely cited, particularly in the treatment community, and is supported by the authors of this document. However, there are those who hold that excessive drinking or drug use is most likely a strong habit or compulsive behavior rather than the result of a disease process.

Stanton Peele's The Diseasing of America (1988) and Herbert Fingerette's Heavy Drinking: The Myth of Alcoholism as a Disease (1988) are two of the foremost works in this area. Both of these authors rely heavily upon the now controversial study of Sobel and Sobel to support their position that since problem drinking is a learned behavior, it can be unlearned. Peele, particularly, spends considerable time exploding the "myth" of once a drunk (addict), always a drunk (addict). He points to numerous instances of circumstances where individuals drink or use drugs heavily (such as American soldiers in Viet Nam) at one point in their lives and return without a drug problem. Peele also contends that alcoholism as a disease was used metaphorically, not literally. This "metaphor" has now begun to be used literally and applied to behavior that Peele believes to be purely psychological in nature, e.g., compulsive gambling and/or promiscuous sexual behavior. He contends that this "metaphor run amok" may lead to many philosophical, ethical, and moral dilemmas. For example, can people be held responsible for their acts while in a "diseased state"? Fingerette (1990) states, "When behavior is labeled a disease it becomes excusable because it is regarded as involuntary....Thus special benefits are provided to alcoholics in employment, health, and civil rights law, provided they can prove their drinking is persistent and heavy" (p. 52). This view is somewhat out of date and distorted in light of the Americans with Disabilities Act of 1990. That act excludes persons who are currently actively using illicit drugs.

SUMMARY

When substances of abuse, including alcohol, are mixed with drugs that are specific to the treatment of various disabilities, the results can be more disabling. Such mixing can make the person mentally dull, affect the ability to learn, result in impaired judgement and insight, and, most importantly, make it difficult for the individual to take control of one's self and one's environment. Recent public and governmental attention on the problem of substance abuse requires everyone's cooperation to minimize enabling and codependency behavior not just for those who abuse substances but for those individuals with disabilities of various kinds who may inadvertently or purposefully abuse substances as well.

REFERENCES

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed., revised). Washington, D.C.: Author.

Arif, A. & Westermeyer, J. (Eds.) (1988). Manual of drug and alcohol abuse: Guidelines for teaching in medical and health institutions. New York: Plenum Medical Book Company.

Benshoff, J. J., & Riggar, T. F. (1990). Cocaine: A primer for rehabilitation counselors. Journal of Applied Rehabilitation Counseling. 21(3), 21-24.

Blum, K., Noble, E. P., Sheridan, P. J., Montgomery, A. Ritchie, T., Jagadesswaren, P., Naogami, H., Briggs, A. H., & Cohn, J. B. (1990). Allelic association of human dopamine D2 receptor gene in alcoholism. Journal of the American Medical Association, 263(15), 2055-2059.

Collins, A. C., & de Feibre, C. M. (1990). A review of genetic influence on psychoactive substances use and abuse. In H. B. Milkman & L. I. Sederer (Eds.), Treatment choices for alcoholism and substance abuse. Lexington, MA: D. C. Heath.

Doweiko, H. E. (1990). Concepts of chemical dependency. Pacific Grove, CA: Brooks/Cole Publishing.

Ellis, A., McInernery, J. E., DiGiuseppe, R., & Yeager, R. J. (1988). Rational emotive therapy with alcoholic and substance abusers. New York: Pergamon Press.

Emrick, C. D., & Aarons, G. A. (1990). Cognitive-behavioral treatment of problem drinking. In H. B. Milkman & L. I. Sederer (Eds.), Treatment choices for alcoholism and substance abuse. Lexington, MA: D. C. Heath.

Fingerette, H. (1988). Heavy drinking: The myth of alcoholism as a disease. Berkeley: University of California Press.

Fingerette, H. (1990). Why we should reject the disease concept of alcoholism. In R. C. Enge (Ed.), Controversies in the addiction field (volume I). Baltimore, MD: American Council on Alcoholism.

George, R. (1990). Counseling the chemically dependent: Theory and practice. Englewood Cliffs, NJ: Prentice-Hall.

Inturrisi, C. (1990). Symposium of pain management of cancer pain. Primary Care and Cancer, 50.

Jaffe, J. (1980). Drug addiction and drug abuse. In A. G. Gilman, et al. (Eds.), Pharmacological basis of therapeutics (6th ed.). New York: MacMillan Publishing Co, Inc.

Lewis, J. A., Dana, R. Q., & Blevins, G. A. (1988). Substance abuse counseling: An individualized approach. Pacific Grove, CA: Brooks/Cole Publishing.

Liska, I. (1986). Drugs and the human body: With implications for society. New York: Macmillan.

Milam, J. R., & Ketcham K. (1981). Under the influence: A guide to the myths and realities of alcoholism. Seattle, WA: Bantam Books.

Miles, W. R. (1972). The comparative concentrations of alcohol in human blood and urine at intervals after ingestion. Journal of Pharmacology and Experimental Therapy, 20, 165.

O'Brien, R., & Chafetz, M. (1982). The encyclopedia of alcoholism. New York: Facts on File Publishing.

Peele, S. (1988). The meaning of addiction: Compulsive experience and its interpretation. Lexington, MA: Plenum Medical Book Company.

Peele, S. (1989). The diseasing of America: Addiction treatment out of control. Lexington, MA: D. C. Heath.

Shuckit, M. A. (1991). Alcohol and alcoholism. In J. H. Wilson et al. (Eds.), Harrison's principles of internal medicine. New York: McGraw Hill Book Co.

Shuckit, M. A. (1989). Alcohol abuse: A clinical guide to diagnosis and treatment. New York: Plenum Medical Book Company.

Turturro, M., Macleod, B., Lorei, J., & Paris, P. (1990). Pain management in the emergency department. Hospital Physician, 29, 37.

Victor, M., & Adams, R. D. (1983). The effect of alcohol on the nervous system. In R. G. Petersdorf et al. (Eds.), Harrison's principles of internal medicine. New York: McGraw Hill Co.

Westermeyer, J. (1986). A clinical guide to alcohol and drug problems. New York: Praeger.

White, J. (1991). Drug dependence. Englewood Cliffs, NJ: Prentice-Hall.

Wright, G. N. (1980). Total rehabilitation. Boston: Little, Brown, and Company.

Chapter III

ASSESSMENT OF SUBSTANCE ABUSE AS A COEXISTING DISABILITY

Individuals with primary and secondary disabilities of substance abuse are being found in rehabilitation caseloads at increasing rates. Surveys have indicated 29% of the average counselor caseload had a primary or secondary disability of substance abuse (Benshoff, Grissom, & Nelson, 1990).

Increased use of substances among persons with disabilities can become an "equalizer" in dealing with the nondisabled world which supports the use of chemicals to "party" or deal with painful feelings. Vulnerability to increased use is heightened with easy access to medications and drugs from medical professionals, frustrations and stress in dealing with chronic pain, spasticity, and increased limitations (Stude, 1990).

Individuals who have degenerative conditions and progressive diseases such as multiple sclerosis, arthritis, post polio syndrome, etc., may be highly susceptible to substance abuse in dealing with pain, depression, and other adjustment processes.

Sometimes the physical and medical needs of a primary disabling condition are of such magnitude that an existing abuse problem may be overlooked. Failure to deal with the problem can threaten and even sabotage the entire rehabilitation process. Unrecognized substance abuse has potential for becoming a greater barrier to employment than the primary condition bringing the individual to vocational rehabilitation in the first place (Stude, 1990). Chief among these barriers are complications of psychological and social adjustment to the disability, impaired learning processes, decreased chances for vocational preparation and employment, and increased risk of alcohol and other drugs mixed with treatment medications, resulting in adverse medical effects (Mitiguy, 1990). Thus, regardless of the primary disability, the substance abuse must be addressed and integrated into the rehabilitation process before successful outcome to the primary disability objectives can take place.

Rehabilitation counselors are in a unique position to recognize the problem. Then they can intervene by recommended treatment of the disease. However, many counselors tend to minimize the existence of a drug or alcohol problem even when signs and symptoms are obvious. They often feel a reluctance to broach the subject with the client and may totally avoid it altogether. By ignoring the problem, counselors are participating in enabling and perpetuating the disease. Greer (1989) summarizes this point in the following statement:

> The rehabilitation counselor who knows that a client is abusing alcohol or other drugs and that the abuse may interfere with the rehabilitation program, is professionally obligated to bring this fact to the client's attention. The rehabilitation counselor should be prepared to actively approach the abuse with the client in an empathetic, supportive manner. All available intervention options

should be discussed and assessment as to extent and treatment procedures should be recommended. Intervention to address the substance abuse should become a part of the IWRP with the client's consent. Should the client refuse intervention and continues abusive behavior that may impair potential benefits from rehabilitation services, the counselor may terminate services to the client. Services should be terminated only after reasonable effort to secure the client's compliance has failed. (p. 145)

It is important that counselors examine and become aware of their own attitudes and how their attitudes affect their perception toward substance abusing clients who have other disabilities. According to Greer, the attitudes held by rehabilitation counselors toward a consumer who is also a substance abuser greatly influence their approach in recognizing and addressing the problem. Greer characterizes these attitudes as follows:

Low expectation: Many counselors indicate minimal to nonexistent rehabilitation potential for this group.

Grieving rights: Many nonimpaired individuals view individuals with disabilities as being in a state of loss. Therefore, the individual is expected to grieve the loss by exhibiting such behaviors as denial, depression, and lack of motivation. With this attitude comes the belief that abuse is justified by the client's lack of "normality."

Misplaced sympathy: Many nondisabled individuals view persons with disabilities--especially disabilities from birth--as being naive, innocent, and free from the vices of the nondisabled. When a counselor who holds this view encounters a manipulative client, the results can be extremely counterproductive.

Counselors use: If counselors consume to the point of abuse yet consider it the norm, it is quite possible that their attitudes toward alcohol or other drug use among future clients may be inappropriately permissive. (pp. 144-145)

It is perhaps most important to realize that alcoholism and other forms of addiction are chronic, progressive diseases that are often fatal when left untreated. Mounting research indicates that treatment does work. Increasingly larger numbers of individuals are now in recovery as a direct result of successful arrest of the disease through treatment. However, few addicted individuals begin the road to recovery on their own. Most often the pattern of abuse must be broken through intervention in a way that demonstrates that cessation of use and lifestyle change are possible. Everyone agrees that the earlier the intervention occurs in the individual's addiction, the better the prognosis for recovery.

Once the counselor becomes aware of a potential substance abuse, it becomes essential to obtain an evaluation of the client's substance abuse condition from a professional (i.e., psychologist, psychiatrist, or physician) who is credentialed in this specialty area or is affiliated with substance abuse treatment programs. The evaluation should reflect:

1. The history of the disorder, including a detailed description of the nature and

severity of the addiction, indication as to whether the client has accepted the reality of the addiction, and whether or not the client is willing to assume responsibility for available treatment and support programs; and

2. Recommendations as to treatment (inpatient or outpatient).

The client should agree to participate in available and appropriate treatment in order to progress with services. It is most essential for the counselor, client, and treatment therapist to work in concert so as to prevent manipulation of accommodating agencies by the client and to reinforce therapeutic approaches. The counselor should follow the case until closure in cooperation with other agencies or individuals involved in the client's ongoing treatment and recovery.

Signs and Symptoms of Addiction

Determining the presence of a coexisting substance abuse disability can be quite difficult for the vocational rehabilitation counselor when the client does not want this information to be known. It is, therefore, essential that counselors understand the nature and course of the addiction process. With this understanding, the counselor can be sensitive to environmental factors, genetic predispositions, and the addictive potential of different drugs which might indicate the coexistence of a substance abuse problem (Bell, 1990).

Substance abuse and dependence as defined by DSM III-R (1987) is not determined by the quantity of the substance consumed but by the degree to which the person has lost control of its use. Thus, loss of control of use of the substance is the major feature defining addiction. An additional major characteristic of addiction is denial by the client that dependency or abuse exists or is a problem. Chemically dependent clients are usually in denial concerning the amount and frequency of use. It is, therefore, usually helpful to interview a family member or friend who knows the personal habits and routines of the client. These individuals can often provide clues as to the accuracy of the client's reported history of use or nonuse. In some cases, family members may suspect, yet not be certain, that the client is using drugs.

It is sometimes helpful to interview family members (with the client's permission) with questions concerning changes in the client's regular routine that may be indicative or symptomatic of drug use (e.g., late night hours, missing work, unusual financial problems, unexplained irritability and moodiness, depression, overly submissive and remorseful behavior, change in leisure-time activities, unfamiliar or new associates, loss of valuable items such as jewelry). Many family members may observe, yet not understand, the meaning of these indicators as forecasters of an addictive pattern of behavior leading to progressively negative consequences which will eventually affect all areas of the client's life.

INDICATORS OF SUBSTANCE ABUSE IN MAJOR LIFE AREAS

Social

Social problems can be an early indicator of substance abuse. The client may resist

socializing with friends who do not drink or use drugs. The client may become aloof and secretive. Friends may express concern about the client's drinking and/or drug using behaviors. The client may begin to socialize in places known for drug trafficking and/or frequent alcohol consumption. The client may experience "morning after" regrets for engaging in inappropriate conduct the day before, e.g., fighting, promiscuity, over spending, etc.

Family

Family conflicts can be a symptom of chemical dependency. Marital conflicts centering around financial problems, unexplained absences from the home (especially at night), chronic irresponsibility, and broken promises are common. The acting out of other family members, (e.g., children) and the depression of nondrug using family members are also possible indicators of substance abuse problems.

Personal

Substance abuse certainly can be symptomatic of dissatisfaction with life as perceived by the client. Depression and/or hostility toward the disability is common. Labile and wide mood swings can be indicative of substance abuse problems as well as expressions of boredom, loneliness, and hopelessness.

Medical

Inability to cope with medical problems can contribute to substance abuse, e.g., the inability to ambulate, impairment of bowel and bladder function, loss of sexual function, chronic pain, sleep disturbance, malnutrition, hypertension, gastritis, ulcers, heart disease, intestinal difficulties, emphysema, diabetes or hypoglycemia, and hepatitis (Evans & Sullivan, 1990). Physical injury due to accidents is also associated with substance abuse (see Table III-1, Prevalence of Trauma Among Outpatients with Alcohol Problems and Social Drinkers, Skinner, Holt, Schuller, Roy, & Israel, 1984). The counselor may use the questions in Table III-1 to further explore the existence of substance abuse related incidents.

Legal

Substance abuse often leads to law violations. Typical examples are: arrest for driving while intoxicated, reckless driving, assault, prostitution, drug trafficking, possession, breaking and entering, burglary, grand theft auto, shoplifting, and passing worthless checks.

Employment

The job is usually the last area to be affected by substance abuse. Indicators of substance abuse that appear in the work place are absenteeism, tardiness, lower work productivity, carelessness leading to accidents, frequent sick leave, and hypersensitivity to feedback from supervisor.

Table III-1
Questions on History of Trauma
Outpatient Social Drinkers with Known Alcohol Problems
Matched for Age and Sex

Since your 18th birthday . . .	**Alcoholic** (n=68)	**Social Drinker** (n=68)
Have you had any fractures or dislocation to your bones or joints?	60	28
Have you been injured in a road traffic accident?	40	18
Have you injured your head?	58	16
Have you been injured in an assault or fight (excluding injuries during sports)?	47	6
Have you been injured after drinking?	60	3
Scale Mean $\pm$ Sd	**2.6 $\pm$ 1.7**	**0.7 $\pm$ 0.9**

A thorough interview covering the history of the client's drinking pattern is necessary to differentiate personality pathology, drinking problems, related physical problems, and interrelationships among these factors.

The diagnostic interview by the counselor may include exploration of the following:

1. What specific functional limitations are associated with the client's drinking?

2. At what age did the client begin drinking?

3. What particular stressful events were associated with drinking or drug use onset?

4. Can other stressful events such as divorce, job-related problems, or loss of a family member be associated with the progression of the illness?

5. When did the client begin to recognize that drinking or drug use constituted a problem? How did the client attempt to deal with it?

6. At what time did the client begin experiencing withdrawal tremors and if applicable, when did he/she begin early morning drinking in an effort to control them?

7. When, if applicable, did the client begin to drink daily? Has this continued?

8. When was dysfunction on the job first evident as a result of alcohol intake? How has it progressed?

9. Are other drugs abused in conjunction with alcohol? If so, what are they and what patterns are associated with their abuse?

CRITERIA FOR PSYCHOACTIVE SUBSTANCE DEPENDENCY

The Diagnostic and Statistical Manual of Mental Disorders Third Edition, Revised (DSM III-R) (1987) lists nine criteria for psychoactive substance dependency. Any three of these criteria are sufficient to establish the diagnosis if they have persisted for a month or more, or have occurred repeatedly over a long period of time. The criteria and information about their application are as follows:

1. Substance often taken in larger amounts over longer period than the client intended.

2. Persistent desire or unsuccessful efforts to cut down or control use.

3. A great deal of time spent in activities getting the substance, taking the substance, or recovering from its effects.

4. Frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home, or when the substance use is physically hazardous as in operating dangerous machinery or driving a car.

The criteria discussed thus far highlight the importance of evaluating control issues. The important point is that addicted clients use more of the drug than they intended. In an attempt to control usage, the consumer may establish rules as to amount and frequency of use as well as associates with whom they use. For example, "I only drink wine"; "I only drink after 5:00 p.m."; "I never drink alone"; "I only have one drink per hour." However, due to the progressive nature of the addiction process, the client usually does not manage to control the use of the substance.

5. Important social, occupational, or recreational activities given up or reduced because of substance abuse.

Chemically dependent persons will rarely admit this; therefore, it is important to compare changes in the social history to events in the drug use history.

6. Continued substance use despite knowledge of having a persistent, or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance.

Many clients will not make the connection between their substance use and problems in their lives. Due to denial, they will attribute social problems, legal problems, financial problems, etc., to other people and situations. They will not recognize the significance of their

use in creating the problem.

7. Marked tolerance: need for markedly increased amounts of the substance in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount.

Tolerance is another area which is particularly susceptible to denial. Oftentimes substance abusing persons do not recognize that they are drinking or using more of the drug than when they initially began their drug use. Through careful history taking, it is possible to document a significant and dramatic increase in the amount of alcohol or drugs consumed compared to the person's original consumption level. A 50% increase in amount of alcohol consumed is considered to be a marked increase (Michael, Miller, & Mulkey, undated).

8. Characteristic withdrawal symptoms: withdrawal from cocaine presents subtle and atypical symptoms compared to withdrawal from alcohol and heroin. Withdrawal from crack cocaine involves increased periods of sleeping during the first 24 to 48 hours, increased consumption of food, oftentimes marked depression, with feelings of hopelessness and helplessness.

9. Substance often taken to relieve or avoid withdrawal symptoms. (This is usually a symptom of late stage addiction.)

INTERACTION OF ADDICTION AND DISABILITIES

There is little prevalence and incidence data on persons with physical disabilities who have a coexisting substance abuse disability. There is comparatively more available information on persons with mental disorders who have a coexisting substance abuse (alcohol) disorder. Consequently, the mentally ill substance abusing population will be discussed, and attempts will be made to apply, where appropriate, diagnostic principles and issues to other disability groups. The discussion will examine common characteristics generally found among individuals with any disability.

Similarities of Disability Groups Without Regard to Coexisting Substance Abuse

1. **Psychological ramifications of the disability**: Individuals experience stress reactions associated with the stress adaptation syndrome, i.e., shock, anxiety, bargaining, denial, depression, anger, acceptance, adjustment.

2. **Family issues**: The family's reaction to the disabled person and visa versa is often problematic. Issues of codependency, role reversals, marital problems, etc., will affect the rehabilitation process.

3. **Service delivery model**: An interdisciplinary service model is indicated for the disabled population. Counselors are challenged to include treatment team professionals as well as non-professionals (e.g., spouse, parents, etc.) to ensure a comprehensive diagnostic evaluation.

4. **Eligibility criteria for vocational rehabilitation services**: Eligibility criteria are applied in the same manner for all disabilities.

Similarities Found in Disabled Persons with Substance Abuse Problems

1. **Client as informant**: Substance abuse coexisting with another disability (particularly in the case of mental disorders affecting major thought processes) often results in unreliable historical information (e.g., onset of substance abuse, frequency and amount of use, severity of consequences of use, assessment of tolerance, etc.). This results in the need for collateral information on the client. Research suggests that people will give more accurate self-reports of negative consequences and frequency of use than of actual amounts consumed.

2. **Masking effect**: Withdrawal symptoms may be masked by coexisting disabilities, e.g., psychiatric symptoms or depression related to a coexisting physical disability. For example, this is often seen in the traumatically brain injured person whose impulsivity and labile mood may mask subtle withdrawal symptoms such as irritability, depression, and restlessness.

3. **Progression of use**: The course of the coexisting chemical dependency may be difficult to determine due to the coexisting mental or physical disability. For example, mentally ill persons often have a limited capacity for accuracy of self-appraisal and therefore prevent the rehabilitation counselor from obtaining reliable information on drug use history. The traumatically brain injured (TBI) person's hypersensitivity to even small amounts of alcohol may result in an accelerated progression of substance dependency. In effect, TBI significantly shortens the initial "recreational" substance use period as well as shortens the abuse period leading to comparatively early onset signs of addiction. This tends to increase the strength of denial and contribute to increased severity of addiction.

4. **Tolerance**: Tolerance to alcohol and drugs may be difficult to assess in the disabled person with a coexisting substance abuse disability because of sporadic and binge use. The TBI client, with increased hypersensitivity to alcohol, may have a significantly diminished tolerance effect. The TBI client may actually report a reduction in the amount of alcohol consumed (compared to pre-injury amounts) yet become addicted due to decreased tolerance.

Substance abuse in the mentally ill, deaf, TBI, and chronic pain populations (especially young males) is high in comparison to other disability groups. Therefore, the vocational rehabilitation counselor should be especially alert to indicators of addiction with these populations. Mentally ill consumers with a coexisting substance abuse disability often exhibit frequent episodes of escalating symptoms without apparent psychosocial stressors. Failure to follow through on appointments, despite supportive efforts of the counselor, is another clue. Substance abuse (e.g., stimulant use such as opium and marijuana) can cause persons with schizophrenia to experience florid psychotic flare-ups even when taking antipsychotic medication. Alcohol can increase the acting-out behavior of TBI clients, make signing less clear for the deaf client and cause more withdrawal in the deaf client, and increase symptoms in psychiatric

clients. The substance abusing persons with a spinal cord injury may develop medical complications (e.g., decubitus ulcers) due to gross noncompliance with medical advice.

OTHER METHODS FOR DETECTING SUBSTANCE USE

Physical Tests

Blood and urine analysis done on a random basis can be quite effective in detecting alcohol and poly drug use. The detection period varies for different drugs and alcohol.

"Bloodshot eyes" is a common sign of alcohol or drug use (e.g., marijuana). Short-term memory problems can also be a sign of alcohol and drug use. This sign is compromised, however, with the TBI client who typically exhibits memory problems. High current blood levels of a psychoactive substance without signs of intoxication suggest tolerance. Elevated blood pressure readings suggest possible recent marijuana use. This sign is compromised by persons with hypertension or those addicted to nicotine, which tends to elevate blood pressure.

Inventory Tests

Inventory tests can provide accurate information regarding substance use; however, respondents can, and often do, fake answers. The Michigan Alcohol Screening Test (MAST) is a well known inventory. However, it does not control for faking. The Alcohol Use Disorder Inventory Test is gaining in popularity as a valid indicator of use and many prefer it over the MAST. Some inventories attempt to control for invalid answers by incorporating validity scales. (**Note:** Descriptions of the following scales [tests] can be found in Evans & Sullivan, 1990.) The Personal Experience Inventory targets adolescents and has items to detect faking.

The Minnesota Multiphasic Personality Inventory (MMPI) is a commonly used diagnostic tool that has items to detect faking. The MacAndrews Scale (made up of MMPI items) is designed to detect alcohol problems. It provides accurate results with individuals who honestly answer questions regarding their alcohol use. When used in combination with the MacAndrews Scale, the Positive Malingering Scale is a good source for detecting individuals who attempt to minimize their alcohol use. The validity of these scales for detecting polysubstance abuse has not been established.

The Substance Abuse Subtle Screening Inventory (SASSI) and the Addiction Severity Index (ASI) can also be used to obtain information regarding one's use of alcohol. The C.A.G.E. questions can provide an initial indication of possible alcohol abuse. However, the answers can be easily faked. The four questions composing the C.A.G.E. are:

1. Have you ever felt you ought to **C**ut down on your drinking?

2. Have people **A**nnoyed you by criticizing your drinking?

3. Have you ever felt bad or **G**uilty about your drinking?

4. Have you ever had an early morning Eye-opener drink to steady your nerves or for a hangover?

Positive responses to any two questions are a possible indication of alcohol abuse.

DIAGNOSTIC PRINCIPLES

Evans and Sullivan (1990) provide diagnostic principles for dually diagnosed, mentally ill substance abusers. These principles will be discussed with implications for other disability groups as applicable.

1. The psychiatric disability should be considered primary and the substance abuse disorder secondary if the client's history indicates the person was mentally ill first and then became a substance abuser. The primary/secondary distinction is relevant in establishing the differential diagnosis; the coexisting model is relevant for the treatment phase. Knowing which disorder came first may be prognostic in determining response to treatment. In vocational rehabilitation the disability that causes the most functional limitation is considered the primary disability for eligibility purposes. Getting an accurate history as to substance abuse onset is difficult. De-emphasizing individual symptoms and relying more on the age at which the individual met all criteria for a disorder may be helpful. Individuals whose substance abuse predates an already existing disability are likely to suffer premorbid dysfunctional adjustment associated with the abuse in addition to the added disability.

2. Persons with substance abuse as a coexisting disability present symptoms that are qualitatively different from those seen in persons without a coexisting disorder. Factors such as frequency, intensity, severity, and course of the disability are significantly affected.

3. Before a clear diagnostic impression can be established, the individual must go through a period of detoxification. This is particularly true for persons who exhibit signs of mental illness. The recommended period of detoxification varies; however, a workable period of abstinence is four weeks.

In reference to persons with mental illness and a coexisting substance abuse problem, Evans and Sullivan (1990) recommend the following adjunct rules:

1. When there is a question as to whether there is a mental illness coexisting with a substance abuse problem, determine if the client has a family history of mental illness. Research has indicated a genetic component to schizophrenia, bipolar disorder, and some anxiety and depressive disorders.

2. If there is a history of multiple treatment failures, e.g., leaving before completion of treatment, noncompliance with program rules, relapsing during or after treatment, etc., this may indicate a coexisting disability and not simply lack of

motivation for treatment. The coexisting disability could be substance abuse in the case of a mentally ill person or mental illness (particularly depression) in the case of a substance abusing client.

3. A positive response to a trial of (nonaddictive) neuroleptic medication gives support to the presence of a coexisting mental disorder. This trial period should proceed after the client has been detoxed, yet continues to exhibit signs of mental illness.

DUAL DIAGNOSIS TREATMENT

Evans and Sullivan (1990) addressed situations which call for dual diagnosis treatment. The general principle concerning this is that once it is determined the person has a substance abuse disability coexisting with another disorder, dual diagnosis treatment is indicated. Where simultaneous treatment for the person with coexisting disabilities does not exist, resource development creating such a service is needed.

Drug treatment programs that do not treat coexisting disabilities simultaneously often result in failed treatment outcomes. Persons with schizophrenia often drop out of group drug treatment because of their deficits in tracking and understanding information and because of deficits in applying general principles to specific situations. In addition, these persons may become increasingly psychotic (even when stabilized on medication) when exposed to high levels of emotional expression in drug groups and to demands for performance on their written work (as required in AA Twelve-Step programs). The traumatically brain injured person may also overreact to confrontative encounters with group members on issues of denial. Severely depressed persons may become more suicidal when made to list all the negative consequences of their substance abuse. Deaf persons may not receive the out-of-group support so important to recovery because of communication problems with drug group members. The normal flow of group discussions may also be affected by persons with coexisting disabilities. Interpreters may have a difficult time interpreting group discussions. The manic person may talk too much. The borderline personality person may alienate group members because of their chronic focus on problems the group has repeatedly addressed.

REFERENCES

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.

Bell, P. (1990). Chemical dependency and African-Americans: Counseling strategies and community issues. Drug Free Schools and Communities, 4(1).

Benshoff, J., Grissom, J., & Nelson, R. (1990). Job placement strategies with substance abusers. Journal of Job Placement, VI(2), 16-20.

Evans, K., & Sullivan, M. J. (1990). Dual diagnosis: Counseling the mentally ill substance abuser. New York NY: Guilford Publications.

Greer, B. (1989). Alcohol and other drug abuse by the physically impaired. Alcohol Health & Research World, 13(2), 144-148.

Michael, J. H., Miller, J. H., & Mulkey, S. W. (undated). Vocational rehabilitation and chemically dependent youth: Eligibility determination and the IWRP. Knoxville, TN: Regional Rehabilitation Continuing Education Program, The University of Tennessee.

Mitiguy, J. (1990). Cycles of abuse: Alcohol and head trauma. Headlines, 3-4.

Skinner, H. A., Holt, S., Schuller, R., Roy, J., & Israel, Y. (1984). Identification of alcohol abuse using laboratory tests and a history of trauma. Annuals of Internal Medicine, 101, 847-851.

Stude, E. W. (1990). Professionalization of substance abuse counseling. Journal of Applied Rehabilitation Counseling, 21(3).

Chapter IV

THE PROCESS OF TREATMENT

This chapter will examine the process of treatment for chemical dependency. As you read this chapter, think of treatment as an ongoing process that continues over a long period of time. It is much more than a specific 28-day period during which the client is in a substance abuse program getting "cured."

Although substantial change can be seen in many people in a few weeks of treatment, the process of treatment and recovery usually takes years, not weeks or months. The phases of the process can be divided into five fairly distinct periods: discovery, confrontation, evaluation and recommendations, treatment, and aftercare.

DISCOVERY

It is discovered by others that Jim has a drinking problem. Discovery might happen as suddenly as a supervisor opening an office door at 9:00 a.m. and finding a subordinate drinking. Although suspicions might have been in the air for months, even years, this event brings all the suspicions into sharp focus and makes possible a direct confrontation or "intervention." Discovery might be the day when a wife finally decides that her husband does drink too much or at the wrong times. His drinking is out of control and qualitatively different from social drinking. He needs help. As with the supervisor, she might have felt for a long time that her husband's drinking was more than just drinking. At the point of "discovery," she allows the real impact of all of her feelings and experiences to hit her.

From the time of the discovery, those who do the discovering can no longer ignore the substance abuse and related behavior without feelings of guilt, self-deprecation, and anger. They now know that something is definitely wrong; they know (at least in part) what it is, and they know that something must be done. They, also, know that **they**, in some way, must be involved in the next step of the process.

CONFRONTATION

Because the word, "intervention," has come to mean a specific process to many professionals, the word, "confrontation," will be used. In confrontation the substance abuser is made aware that hiv/her drinking/drug abuse has come to the attention of other people who are affected and who wish to change their relationship with the abuser. That, stated simply, is confrontation, and it can take many forms.

It can be as simple as a boss telling a secretary that she must do something about her drinking or lose her job. It can be as complex as a carefully orchestrated and rehearsed session in which the abuser is invited to meet together with hiv/her family and relatives and maybe the

abuser's boss. A trained addictions counselor leads the meeting (Johnson Institute Model), and each person present tells the abuser in clear, direct words what effect the abuser's drinking/drug abuse has had on him/her. Each person states, then tells, the abuser the changes he/she are going to make in his/her personal relationship with the abuser. Those present clearly state they will not be further victimized. They also give the abuser a realistic view of what is happening regarding the abuser's chemical dependency.

The confrontation reminds the abuser that he/she lives in relationships with other people, whether always conscious of this or not. The abuser is not told what to do, but is given information (if requested) and is informed that, if the abuse continues, certain definite changes will be made in these relationships.

Confrontation opens the secret of addiction for discussion; addiction cannot ever again be returned to the closet. Since addiction thrives in and feeds upon secrecy and indirectness, confrontation in itself is actually a form of early treatment. It is made very clear, regardless of what kind of confrontational model or meeting is used, that the abuse is not approved of, is destructive of every form and definition of "health," and will no longer be ignored.

A Short Story About the Effectiveness of Confrontation

The experience of a client in treatment, as told to a rehabilitation counselor, might be helpful. An alcoholic had been inducted into the Army and was continuing his abusive drinking in service, though not aware that it was being noticed by anyone else. One evening, his sergeant asked him to go with him to an Alcoholics Anonymous (AA) meeting on the base. Harry, the alcoholic inductee, was surprised to discover that his sergeant was a recovering alcoholic and that his sergeant felt that Harry also was an alcoholic. In his state of shock, he could not think of a way to refuse the invitation, so he went to the AA meeting. He later told his counselor that the meeting was an eye-opener for him. He said that, for the first time in his life, he heard people (who knew what they were talking about) saying that if he ever stopped drinking, it would be one of the hardest things he had ever done.

Instead of being dejected by this position, he said it made him feel good. His reason for feeling good and actually hopeful after hearing that opinion was that all of his friends back home, and his family and relatives, had always told him that stopping drinking was very easy. All he had to do was put the stopper back in the bottle and shove it away from him and forget it. Harry had tried many times to do that without success. Since others had told him it was so easy, he had repeatedly felt that he must be the weakest, sorriest person on earth. Then, in the base AA meeting that night, he heard that he was right! It really was hard, not easy, and if he had a hard time giving up the drinking, it wasn't because he was weak and sorry. It was because the task was formidable and it was very appropriate to ask for help. He now had confirmation of his feelings and felt he could trust his perceptions and give himself credit for the size of the job he was trying to do.

The problem with chemical dependency is that denial is one of the chief symptoms. The addict is the last person to know the problem.

Like any other disease, there is no purpose in disguising the diagnosis with another term

such as abuse or misuse. Without early intervention treatment is delayed. The disease will progress and will get worse if left untreated. It can become chronic, but can be arrested, and chemically dependent persons can live a healthy and productive life, as long as they abstain. Relapse is frequent, showing the chronicity of the disease.

How does one intervene to prevent progression of the disease? There are a number of problems that need to be understood prior to intervention. Intervention in itself has its problems. John Price from the Department of Psychiatry, University of Queensland, believes that we are not doing interventions as often as we should.

> It is said that we do not intervene because we are too pessimistic in dealing with the chemically dependent persons. We do not know whose responsibility it is to intervene. We do not know when to intervene. We do not always know what interventions are available, and of these, what intervention is appropriate in a given case. Other reasons are, fear of being overwhelmed by the many problems that may be uncovered, reluctance to abandon what we are already doing. (Price, 1988, p. 346)

Some are afraid to lose a friendship and some think it is an interference in another's life. Others do not want to misjudge, and a number do not want to be involved.

There is also a need to understand the delusional system of the addicted person. Rationalization, projection, denial, repression, and self-delusion create barriers to self-awareness. Knowledge about these mental mechanisms by the interveners can affect the outcome of the intervention process.

What is intervention? According to Williams and Knox (1987), it is:

> ...a process in which an individual is not allowed to avoid the natural and logical consequences of his or her drug/alcohol related behavior. The process is one using increasing levels of negative consequences of drinking-related behavior until experiencing the consequences is deemed worse than confronting the drinking problem and accepting help that is offered. (p. 98)

The purpose of intervention is to halt the delusional system so that the person will accept the help to arrest the disease and begin recovery. As an example, possible loss of a person's job becomes the unpleasant consequence which may encourage acceptance of treatment.

The vulnerability of the persons in contact with the addicted person at home, work, through health care visits, and by significant others can affect how the facilitator deals with this problem. The recognition of the symptoms and specific facts about the person's behavior and incidents that have happened because of alcohol and drugs have to be presented to the person in a caring manner. It should be objective and nonjudgmental.

Vocational rehabilitation services are not spared in dealing with the chemically dependent clients. Frequently, referrals come from drug rehabilitation programs. Some clients may have a secondary diagnosis of chemical dependency but may not currently be active abusers. In many

instances, some professionals involved in providing services are inexperienced in the area of addiction. As a result, frequently clients are prematurely discharged from their programs because of active involvement with drugs.

In a Commission on Accreditation of Rehabiiitation Facilities (CARF) accredited state-operated comprehensive vocational rehabilitation program, client interventions are practiced. Physicians cover the center 24 hours per day; case managers, social workers, addiction counselors, vocational evaluators, and training instructors give the program the distinct advantage of involving more than two rehabilitation services providers as part of the intervention team. Below are client histories illustrating the intervention process.

> A 25-year-old, Caucasian female admitted to the center April 24, 1991 for vocational evaluation: Her primary disability was learning disability. Her social history revealed frequent use of alcohol. On admission she was observed to be tremulous, anxious, and tired. She was referred by her case manager to the addiction counselor on the day of admission. On further history-taking, she admitted to drinking alcohol since age 11. Her reported last alcohol intake was three days prior to admission. The addiction counselor requested a meeting with the client, case manager, and physician. During this time she revealed that she had two arrests for drug possession and used marijuana on and off. Clearly there is a history of extensive use of alcohol and marijuana, and she was showing signs of withdrawal. The team members discussed the findings with the client, and she was convinced that she should be referred to a drug detoxification center. She was admitted to a nearby detoxification center the same day.
>
> A 27-year-old, white female was admitted to the center for training in printing. Her primary disability is substance abuse, in remission. She was referred to the addiction counselor for evaluation. Her drug history revealed alcohol use since age 10. At age 11, she started consuming a case of beer a week. She also used PCP, heroin, and marijuana. She is on probation for DWI. While at the center, she married another client. Shortly after her marriage, she began to miss classes. Her training performance deteriorated, and she admitted to drinking alcohol again. She was evaluated for antabuse but she refused the recommendation. Meanwhile she kept cutting classes. Her case manager decided to call for a meeting which included the probation officer, instructor, addiction counselor, and the client. She was informed of her frequent absences, deterioration of performance in training, and violation of her probation. During this intervention, the client requested antabuse which was prescribed and dispensed by the Nursing staff. She attended the client education program, group therapy, signed a contract for random urines for drug screen, breathalized on a random basis, and attended AA at least three days a week. She graduated from printing on time and was hired on the day of her graduation by a local printing company. On discharge she was provided a list of treatment centers in her area by the addiction counselor. She returned to the center six months after graduation and informed us of her sobriety; she is attending AA two days a week.

For the chemically dependent person, intervention is the moment of truth, an act of

caring. It is best performed by at least two or more persons who have witnessed the person's destructive behavior or have knowledge of the effects of drugs and alcohol (physician, chaplain, probation officer, addiction counselor, psychologist,etc.). Preparation, including rehearsals, may be required for an organized and effective strategy. The intervention team or group of persons participating should also be prepared to provide specific comprehensive recommendations or options. Contact with treatment centers for admission prior to intervention should be explored so treatment can be expedited before the person changes his or her decision. Bear in mind that denial is so strong that the person could sabotage the plans. Options should be discussed regarding hospitalization for detoxification, outpatient counseling, AA, and Narcotics Anonymous (N/A). Allowing the chemically dependent person to choose among the options will restore some self-respect and dignity.

Close follow-up by treatment centers, as well as ongoing support group meetings, will further the recovery of the person. Treatment centers in the community can be found in most areas of the country. In the telephone directory of each locality, treatment and support centers are listed. A mental health clinic in the locality is another resource. For persons with physical disabilities, including persons with spinal cord injuries, deafness, and blindness, barriers to accessibility to services may need to be overcome. This calls for the creative thinking and demand for resources by rehabilitation specialists seeking appropriate centers for these high risk groups.

Hitting Bottom

In the typical sequence of events, treatment for AODA follows closely (and is sometimes the first stage of) the admission of the addicted person that he/she has a serious problem with addictive substances. The word "treatment" has many meanings and involves a variety of techniques and settings. However, before discussing treatment, it is important to understand how a person commonly comes to treatment. Addicted persons build an elaborate wall of defense mechanisms from the raw materials of ego defenses, social defenses, and family defenses (e.g., enablers) around themselves. This wall is constructed with great care over a period of years. For persons with other major disabilities, part of the wall may include the rationalization that their other disabilities justify the use of chemicals to escape the reality of their disabling conditions.

Before any treatment is effective, the addicted person must have these defenses removed, or at least breached. The wall of defenses is usually breached in two ways. First, the addicted person reaches a point in his/her usage where he/she can no longer maintain the defenses. When the harsh reality of the consequences of the chemical abuse overwhelm all defenses, the addicted person reaches a crisis point. He/she either accepts the failure of the present life style and change, or continue the addiction knowing that it will only result in further mental and physical deterioration. This overwhelming of the defenses is often referred to as "hitting bottom." If the traditional AA inspired methods of treatment and recovery are used, this erosion of the defenses is required before a person can recover. In other words, the addicted person must accept that his/her life has been controlled by chemicals to the degree that his/her entire life centers around obtaining and using chemicals.

The second way, and most common way at present, that the defensive walls are breached

is through intervention. It was once thought that for addicts to accept help, they had to hit bottom, to "reach a point where they had to admit utter and total defeat" (Deweiko, 1990, p. 229). However, waiting for each addicted person to hit bottom might take years; many would die; and others would suffer from excessive emotional and physical damage. In addition, their families would also suffer considerable emotional damage. In order to avoid these consequences, early intervention is often used. In this process, the addicted person is confronted by employers, friends, family, and helping professionals who honestly and humanely tell the addicted person what they see happening to him/her. Thus, the intervention is a

> ...process by which the harmful, progressive and destructive effects of chemical dependency are interrupted and the chemically dependent person is helped to stop using mood-altering chemicals, and to develop new, healthier ways of coping with his or her needs and problems (Johnson, 1986, p. 61).

From one point of view, early intervention is having the person hit an "artificial" bottom. The goal of the intervention is not to have the person admit to AODA; it is to have the person agree to be "evaluated for possible chemical dependency and to follow the resulting recommendations" (Johnson, 1986, p. 99).

There are other ways to have the addicted person agree to be assessed for chemical dependency and subsequently receive treatment. In recent years it has become common practice to offer persons accused of alcohol- and drug-related crimes a choice between treatment or jail. In other circumstances, employee assistance programs (EAP) will intervene and force the person to choose between treatment and the job. Two questions that must be a answered are: (a) When is this coercion acceptable within the fabric of basic civil rights, and (b) When is compulsory treatment effective (Chafetz, 1990)? Langton (1991) has pointed out that the barriers between voluntary and involuntary treatment have begun to dissolve.

Role of the Vocational Rehabilitation Counselor in Confrontation

Since substance abusers characteristically deny that their "use" is a problem until outside forces make it difficult for them to continue in their denial, confrontation ("constructive coercion") is extremely important in the treatment process. Without confrontation, very few substance abusers would ever seek treatment. Therefore, it is important that those persons in an abuser's life who care about him/her and are convinced he/she has a problem ACT. These persons should use their relationship with the abuser to convince the abuser that he/she has a serious problem. The rehabilitation counselor can clearly state that the abuse is a significant problem, will not be ignored, requires treatment, and that other services will depend on receipt of substance abuse treatment. Any less direct approach puts the addiction in control of the rehabilitation plan.

In many cases, the rehabilitation counselor is the first person who has ever directly and strongly confronted the abuser about the addiction. While not a comfortable position, it is extremely important and allows the counselor to make good use of the relationship. Personal courage, the ability to state simply and clearly what is known, and the ability not to be fooled by denial are required. Counselors are not "hurting" the clients with such confrontation.

Instead they are helping them understand that addiction is a progressive illness that always gets worse.

A vocational rehabilitation counselor not only has the right to refuse services to an abuser who refuses treatment but has the responsibility to do so...both to conserve public funds and to provide constructive coercion that can lead to effective rehabilitation.

EVALUATION AND RECOMMENDATIONS

After confrontation, it is necessary for a person or a group to talk with the abuser about the severity of the addiction, an appropriate program, where such a program can be found, the cost and arrangements to pay for it, and the extent to which family members can and should be involved. This very important phase is one in which the abuser is expected to express some mixed feelings about continuing toward treatment. He/she might say such things as:

> Now that I see my problem and know I can't drink, I don't think treatment will be necessary. I'll just stay away from some of my drinking friends and go to church and stay home and I'll be O.K.

It is helpful during the evaluation/recommendation session(s) to inform the client that addiction is not something that just goes away (though it may suddenly take another form), and he/she owes it to him/herself to try treatment, for selfish reasons if no other.

The most efficient evaluation and recommendation plan is to refer the client to a treatment program. Many treatment programs provide an evaluation and recommendation service separate from actual treatment. Some simply admit a person to their treatment program and use the early days of treatment as an evaluation time. The important point is that the most appropriate evaluations are done by professionals skilled in the evaluation of substance abuse. These professionals are usually found in AODA programs.

Of course, referral to Alcoholics Anonymous and/or Narcotics Anonymous meetings can help an abuser to evaluate his/her own needs and those programs' potential effectiveness for them. The problem with this approach is that many AA and NA groups have no system for communicating with professional counselors and often feel uncomfortable about doing this on an informal basis.

Since some professionals lack real orientation to the field of addiction, referral to a psychologist or psychiatrist for an evaluation prior to treatment can be problematic. Reports seldom mention the addiction as such, and often only as a secondary problem. These professionals may not be comfortable with local treatment services for addiction and may not make such recommendations. Mood-altering medications sometimes are prescribed too quickly by inadequately trained psychiatrists and physicians, complicating the abusers' addiction problem. This warning does not apply to the majority of psychologists and psychiatrists; it is merely to alert the counselor to the possibility of a report of questionable value. Psychiatrists and psychologists who work closely with addiction treatment programs should be used whenever possible. Also, referral to an addiction treatment program probably can include the services of

a psychologist or psychiatrist, if needed.

What is needed in this phase is a sense of direction, some definite thoughts about what is needed next and where these services can be obtained. Since treatment is the first service, the main question is where can it be obtained. The possibilities should be discussed with the consumer and questions answered. A visit to the treatment place by the consumer may help to lessen anxiety, and the rehabilitation counselor should be available afterward to discuss the consumer's impressions.

The counselor should be available to hear the consumer's feelings about treatment and insist that treatment be completed before other vocational rehabilitation services are implemented. A treatment program that can accommodate the coexisting disability (accessible) has to be found. Ability to pay is an unavoidable reality that can limit treatment facility choices. Also, negotiating with an employer regarding time off to participate in a treatment program may be needed. However, the client should not be allowed to use any of these reality factors as a reason not to pursue treatment.

In this phase of the treatment process the client has the opportunity to think seriously about the effect of the discovery and confrontation phases. Although a short time for self-examination and reflection are needed, it is important to move to the treatment phase as soon as possible. Do not allow the clients' anxiety to feed their natural tendency toward denial. Continued movement is important.

TREATMENT

Treatment for addiction may be defined as:

> A process of indeterminable duration by which a person has the opportunity, under skilled supervision, to face and accept his/her addiction, examine its effects on their life, consider healthier responses to the intrapersonal and relational challenges confronting them, and assume responsibility for choosing and practicing a more constructive and affirming lifestyle.

The client's substance abuse problem has been discovered, he/she has been confronted, treatment arrangements have been considered, and plans have been made. The first stage of treatment for many persons is detoxification. This is done under supervision either in a medically-oriented program or in a "social detox" setting that relies less on medications and more on close monitoring and empathetic listening and encouragement (and group support). The type of detox or whether it is needed at all are decisions made by the client and a physician. They may consult with the planned treatment program (since that program may provide appropriate detox). Many persons accomplish detoxification on their own by refraining from the use of alcohol or any other drug for several days.

Detoxification

A person must be clean of his/her drug of choice before the more intensive phase of treatment can begin. A client who comes to the office under the influence needs nothing as

much as he/she needs detox. To try to provide any other service before insisting on detoxification is a waste of time, money, personal energy, and, in many cases, can be dangerous.

Assuming a person can be treated by self-detoxification is foolish and dangerous. In the past, misinformed individuals would say you only need to get alcoholics sober and find them a job. Family members sometimes subscribe to this thinking. Such reasoning shows a gross misconception about addiction and the nature of real treatment. Both thorough detoxification and longer-term treatment of the "addictive inclination" and its root causes are needed if the client is to remain alcohol/drug free, to be reasonably happy, and to grow into a responsible and stable human being.

After detox, the intensive treatment period begins. Whether accomplished in a residential (inpatient) setting, an outpatient (day patient) program, or a self-help fellowship (such as AA), this is the time when the client first begins to take a concentrated, serious look at him/herself and what is happening to him/her. This stage of treatment can last from a few weeks to several months and can cost many thousands of dollars if done in a private treatment center. Because of the cost, insurance companies that used to pay for such inpatient treatment with little questioning are now examining very closely all inpatient admissions. They now prefer that the patient use an outpatient program if one is available and if indications are that the patient can be adequately treated there.

It is doubtful that any convincing relationship can be seen between the type of program selected and the success experienced by the client. When a substance abuser is ready to truly participate in a treatment program, he/she stands a good chance of getting good results, no matter what treatment approach is used.

The client will be asked in treatment to evaluate him/herself in ways probably not anticipated. Present family relationships will be examined, as well as family-of-origin dynamics. Not only will drinking/drugging behavior be considered, but times when the person is sober or straight will be considered as well. In most programs, there will be a strong insistence that family members be involved in the treatment along with the client.

As with other illnesses, the course of treatment does not necessarily run smoothly. Digging into family relationships and seeking to establish new ways of relating and expressing feelings can be threatening. A relapse into alcohol/drug abuse as a result of such therapeutic work is not uncommon. This does not mean that therapy is not working, but that the feelings are being exposed and the first thought may be to seek quick relief. As a rule, therapy is not quick relief. It takes time for people to learn to benefit from and to depend upon the kind of relief that therapy gives as compared to the immediate rush of the drug of choice. As long as the client sticks to the therapy program and resuming contact with it as soon after each relapse as possible, such seeming failures need not be failures at all; they are just part of the treatment process.

Knowing About Treatment Programs

Within the definition of treatment presented above, there is room for many different

treatment approaches, and many therapeutic philosophies currently are being practiced in this country. All of these approaches work with some people, and all fail to work with others. Research into the relative effectiveness of the different treatments is very difficult to do and is always controversial. In the end, persons desiring treatment probably will have to be content with whatever program is available to them in their home state or with whatever is affordable for them.

Counselors should know which programs are available in their locales and become oriented to those programs. The more acquainted counselors are with a program, the more they will tend to make use of it, and the more comfortable they will be in discussing treatment there with the client. The counselor's attitude toward treatment, addiction, and substance abuse can significantly help or hinder the client's acceptance of the problem and the need for treatment. However, the addicted person must always be the one who finally decides the treatment modality on which they will base his/her recovery and rehabilitation.

The counselor should not feel responsible for selecting the "right" treatment program for a particular client and certainly not for the effective use of a program by a client. The counselor should let the client know what programs are available, discuss the choices, and then let the client choose the place that seems to fit best. For the substance abuser with a coexisting disability, the choices might be very few in number. Many addiction programs are not designed to work with persons who have a significant physical or mental impairment.

Treatment is a process, not an event. It is not a four-week stay at an institution or so many months of participation in an outpatient program. It might begin, and often does, with admission to a structured program of limited duration with an intensive introduction to therapy and recovery. However, treatment in the truest sense may well last for years and can even be said to last a lifetime.

Progress and Failure

The process of treatment often includes experiences that will not appear to be "progress" toward recovery. But once a person has allowed the treatment process to "infect" him/her, once he/she truly desires and begins to do the **work** of therapy, everything that happens becomes grist for the therapeutic mill. Negative or destructive events can be used by the "in-process" client as learning and growing experiences. If the client returns to therapy after each painful event to examine what has happened, why it happened, and what it means for present and future living and decision-making, he/she can profit from these mistakes.

The apparently negative happenings referred to above may include relapse to substance abuse, separation or divorce, the loss of a job or valuable possession, or getting arrested. These are not happy events, but they can be used as part of the process of treatment. They can be used to further break down the wall of denial (always a key word in addiction) and are reminders that addiction always involves much more than just the destructive use of a drug. Unhappy events can be used to stimulate deeper therapy and as a way of redefining the foundation issues that feed the addiction. Being administratively discharged from a treatment center for continued use of drugs would not appear to be something potentially positive, yet many people have made constructive use of that event.

The counselor should not feel discouraged simply because the client "bombs-out" of the treatment program or does not make steady, impressive, and obvious progress once treatment is begun. A relapse should not be taken as justification for closure of the case. Diabetics usually have some difficulty staying on special diets, and obese people fight the same battle. Relapses can be valuable learning times. Counselors should see them in this way unless it becomes obvious over a period of time that the client is not learning anything from these experiences.

It is important for the counselor to remain available to the client on terms with which the counselor can accept and feel comfortable. Obviously, a counselor cannot keep a case open forever without some progress being seen. Agency policy may dictate closure of a case after two or three months of no meaningful contact or progress. However, reopening of a case, when it appears that the client is really "ready" for services and is especially serious about treatment, can be a good move.

The Client's Responsibility

It is easier to work with addiction cases if the counselor adopts the position of being available rather than "managing" the case and "directing" the client. The counselor's position is: (a) to assist in the diagnostic and information-giving phases of the counselor-client relationship, (b) to help the client to come to grips with what is happening to him/her, and (c) to outline the needed and available services. The counselor should make it clear as to what is expected from the client and what he/she has to offer the client (i.e., what the counselor will/will not, can/cannot do.).

The primary initiative must always be the client's responsibility. The counselor's role is assisting, supporting, confronting, listening, giving information, at times educating and evaluating, and interpreting, but never taking over the client's rehabilitation. With this attitude, the negative experiences that happen to the client are not so hard to take, because the counselor does not have the feeling that he/she has to do anything about them. The client must do something (or not), and the counselor is available to remind the client of their plan together and to encourage, support, confront, etc. Much of what the counselor does after the plan is written might very well be described as verbal observing.

Is the Client Ready?

Much has been said over the years about the "readiness" of addicted persons to involve themselves in a therapeutic effort. The readiness or receptivity of the clients, their true willingness to actively participate in treatment and rehabilitation, is absolutely essential to their recovery. Nothing can be done to substance abusers by anyone else that will "treat" them. In chemical dependency, the clients must actually treat themselves. They must think about themselves and the important relationships in their lives. They must discover, accept and talk openly about their feelings, especially the most painful and embarrassing ones. They must continually consider the various choices open to them in every aspect of their daily lives. They must, in other words, be willing to "work" on themselves.

The extent to which they show themselves able to do this provides the counselor with a

good estimation of the clients' readiness for employment. A person who works hard on doing the work of therapy probably is capable, also, of working successfully in competitive employment. Seen in this way, a client's participation in therapy becomes a kind of vocational evaluation, and it can be helpful to communicate this insight and perspective to the client early in the rehabilitation effort.

Must everyone just wait for a person to become "ready" for help? Are we all forced into passive positions of virtual inactivity by an "unmotivated" client? No! There are things people around a substance abuser can do, decisions they can make, and actions that can have a motivating effect. However, counselors should not engage in a program of calculated manipulation, designed to make the abuser want help. No one makes an addicted person stop using their drug of choice or make good use of therapy. Probably the worst thing anyone can do in a relationship with an addicted person is to try to control or manipulate that individual. No matter how well intentioned, such action is doomed to fail. It often causes the abuser to become even more entrenched in the addiction by reacting to the manipulative attack from outside and defending the present self. A counselor can forget about "helping" abusers if, in fact, the counselor is endeavoring to change the addicted persons and force them to conform to the image of success that the counselor has for them. Abusers are much better at resisting than other people are at reforming.

Helping the Client Get Ready

The old idea that we must just sit and wait for motivation to strike the client is outdated and harmful. Current intervention techniques help family and other people close to substance abusers to positively influence the abusers toward earlier admission to treatment. Most abusers still have people left in their lives who care about them and would like to play a part in interrupting the addiction cycle. Such persons are encouraged simply to "stand up for themselves" and state openly and clearly the effect that the abuser's drugging/drinking is having on them. Further, they are encouraged to state the ways in which they are going to change in their relating with the abuser (not demand that the abuser change).

Abusers are given the message that they may continue in their addiction and not seek help if they wish, but the significant others in their life are going to begin responding differently to the behavior. This is a stance that those around the abusers can take to truly help themselves, even if such intervention does not "work" and the abusers continue in their addiction. Because no one has to wait for the abuser to change or do anything, much of the feeling of being powerless is lessened for the family. Since the family and others no longer step in to bail him/her out, the abuser is left to face the full consequences of addictive living.

Having to face the consequences of addiction is painful, and that discomfort happens sooner if no one else is enabling the addiction. Formerly, family and others often tried to prevent the abuser from experiencing hurt. This change in response by significant others in the addict's life has produced excellent results, but it is not necessarily a quick, easy, and totally rewarding experience for those others. They are called upon to alter themselves and make changes in their long-held attitudes and ways of understanding what it means to love and be loved. The changes required are deep, and families often experience as much difficulty as the client in their progress toward more healthy living. For them, also, treatment is a process and

not an event.

An employer can make it clear that an employee may continue drinking if he/she wishes, but cannot keep his/her job if he/she does. A wife cannot stop her husband from drugging if he chooses to continue. However, the wife does not have to remain the victim of his habit. She can move out of the house or move him out. There have been cases in which neither person "moved out" but a new stance was taken by the healthier partner (not to be abused anymore and to deal with his/her own life), resulting in positive changes in the substance abuser.

A wife's beginning to take care of herself, by seeking further education, getting into therapy, taking an aerobics course, etc., starts to break up the destructive mutually dependent and enabling relationship. Such action creates an atmosphere of constructive stress. The old "comfortable" (accustomed) patterns of living and relating are altered and the abuser must adjust. In the need to adjust, treatment and rehabilitation can appear as good choices. They were told, on the contrary, that they could continue in their abusing behavior, if they were willing to pay the price.

Rehabilitation Counselor and the Price of Addiction

A rehabilitation counselor can have an agreement with an alcoholic client that the counselor will be available to the client only when the client comes sober for interviews. Another condition could be attending regular Alcoholics Anonymous meetings. For example, the counselor may consider vocational training for the client, but not until the client has participated in treatment for a minimum of six months. Always, there is a price to be paid for the service desired. The client does not have to pay the price, but if he/she does not, the service is withheld. No one has to take abusive or unmotivated behavior from an addict, and to allow such only gives the message that the sick behavior is really O.K. and that other people are willing to adjust their lives to the abuser's sickness.

Taking these actions tells the addict what the counselor is going to do rather than what he/she must do. The counselor is doing what he/she can and not remain as victims of the addict's sickness. Also, the counselor sets an excellent example for the addict to follow in his/her own recovery efforts.

Counselors and other helping professionals have been lured into an enabling position in relating to substance abusers. The preceding statements suggest that there is a better way than victim passivity on the one hand or destructive coercion on the other. "Constructive coercion" is exercised by people close to an abuser who want something better for themselves. Family members, especially, should be encouraged to involve themselves in a program of counseling that will assist them in relating more healthfully to the abuser (and to everyone else in their life). Such counseling is an integral part of almost every addiction treatment program, inpatient or outpatient.

The Essence of Treatment

There is considerable misunderstanding about what is meant by "treatment" for addiction. Many families of abusers think that the addicted person is going to have something done by

treatment personnel, something that will change the person whether they want to change or not. Others, who have the choice between a four-week program and an eight-week program, might select the longer one, thinking that it will be twice as effective. Some families feel there is something almost magical about a religiously oriented kind of program or that the prescribing of medications will comprise the bulk of the treatment.

The essence of most treatment programs could be presented in five questions. These are questions that programs ask the client to consider while in treatment. While they might not be asked in so many words, the questions are implied in the approach of the treatment staff. The questions are asked regardless of the program model. In beginning to answer these questions, the client enters a process that will be ongoing and will involve him/her in much examination of self and relationships with others. The questions are:

1. **Who am I?** What do I really feel and believe? What is most important to me, my priorities in life? What do I think of myself, and what do I think other people think of me? Who are the important people in my life, and how do we make use of each other? What do I hate? What makes me angry, sad, scared?

2. **What do I want?** This is an all-inclusive question that can involve everything from a desire for more education to a wish to be more personally assertive. Many substance abusers have a tendency to hide their strongest wants and needs, their own individuality, under a cloak of passivity and dependency. They then explode when under the influence in a rush of self-affirmation, claiming feelings and wants that contain much truth but that also are exaggerated and distorted by the drug of choice.

   Most substance abusers tend to be either irritatingly rebellious or frustratingly compliant and pleasing when sober. Since both masks place the abuser in the position of responding to the feelings, wishes, demands, or expectations of others (rather than "coming from their own center"), both are really reactive behaviors.

   It is of vital importance in treatment that the abusers become aware of their own true wants and needs, accept them, and state them to other people. It is especially important that these truths about themselves be expressed to their significant others. Some of the hardest work that most people do in therapy revolves around the answering of this question. It is closely related to a person's assuming responsibility for his/her own life, including their addiction.

3. **What price must I pay to have what I want?** There is always a price. It can include alienation and/or separation from old friends and family members, even divorce. The price might include a move to another town, a different kind of job, or beginning to think of oneself as being of value (which can be difficult to accept after years of self-deprecation). Many people, seeing the price that must be paid for self-actualization, decide to remain as they are and not seek their real wants.

4. **Am I willing to pay the price?** This is the point at which many persons decide to stay the way they are rather than risk growth, of which sobriety is a part. They are

not willing to pay the price, at least not today. They may be willing when present circumstances become more painful--more painful than the price to be paid for change. When family members let a substance abuser experience the consequences of his/her abuse, the abuser may decide that it is now worth risking the price to grow, rather than continue to pay the rising cost of drinking/drugging. It can be seen, then, that an enabling spouse not only makes of him/herself a victim (by absorbing consequences for the abuser's sick thinking and behavior) but actually postpones the time when the abuser might seek treatment.

It is when the abuser is wrestling with the question of willingness to pay the price that he/she might miss appointments with the counselor, come to the counselor's office under the influence, or drop out of treatment or a training program. It can be helpful, though painful, if the counselor at such a time can invite the client to actually restate what he/she wants, the price to be paid, and the commitment to pay it. Looking again at these realities with a reality-oriented professional, stating them aloud to another person, can help to get a person back on track. It is an interesting phenomenon: at a certain point in a growth process, being able to say openly, "I can't do this!", can make it possible for the abuser to do whatever seems impossible. Helping a client to accept the way things **are** can help him/her to move beyond the way they are to the way they need to be.

Focusing again on one's own willingness to grow also puts the emphasis back on the client as the one primarily responsible for his/her own recovery and makes it more difficult for him/her to just blame others for their problems.

5. **How can I begin, right now, to pay the price and start moving toward what I want?** The important word is "now," not tomorrow but right now. Having gone through the other four steps, abusers can defeat their own healthy progress by not beginning immediately to make some small step toward what they want. They might not be able to change jobs today, but they can write a couple of letters of inquiry, or make a call, or revise a resume, or sign-up for a refresher course in a needed subject or skill. A visit with estranged parents might not be possible, but a letter can be written and mailed today. Such immediate action to support the newly expressed decision helps the person to gain confidence in their ability to progress and overcome the fear of change and growth. Actually doing something, no matter how small, enhances a sense of power and self-esteem.

   A characteristic of addicted persons is that they tend to tackle too much too quickly, become frustrated when anticipated successes are not realized, and fall back into a mood of self-pity and inertia. Concentrating on smaller tasks that can be done today keeps them aware of a self that can do rather than a self that fails.

It should be remembered that the process of treatment must go beyond just attaining sobriety. Some persons become sober, stay sober, but remain rather miserable people, having no real contentment or pleasure in their sobriety. Essentially, what the growing substance abuser is headed toward in recovery is the same that all the rest of us probably want for ourselves:

1. Awareness of feelings and acceptance of all feelings as being of value; some may hurt, but none are "bad";

2. To express their feelings and call them by their proper names in the presence of other people (an accepting, affirming group is a good place); let anger be anger, not "upset";

3. To be aware of what other people feel and accept their feelings as they are without trying to change them or judge them. It actually helps us to listen to other people express their feelings; listening as well as talking is therapeutic for us;

4. To become aware of their choices in life. Other people in their communication with us can help us, even when they do not mean to do so, to be more aware of our choices so that our lives do not appear as limited in possibilities as we thought;

5. To be aware of their effect on other people. They need to know how other people feel, for example, when they are around others. They don't have to do anything when they find this out, necessarily. They just need to know how they come across to and are experienced by other people;

6. To be aware of how they are affected by other people--to see the connection between what others say and do and what they (the abuser) feel. They also need to accept that the way they feel about themselves can determine how other people relate to them. They might feel that others are angry with them, when they actually feel their own anger at themselves;

7. To accept responsibility for their own life, feelings, decisions, and actions. The person who is merely trying to "please" or "defeat" someone else is actually making them responsible for his/her behavior. It helps us to continually be asking ourselves, "What do I really want?";

8. To learn to be themselves, but to do that in company with other people who are also trying to be themselves. A person usually does not develop problems in isolation from other people and does not really solve his/her problems apart from other people. Personal freedom has little meaning except as it is experienced in the community with others who are experiencing varying degrees of freedom in their own lives;

9. To learn to do what must be done, what needs to be done, within the boundaries of time and social propriety that affect all of us. To cooperate with others, to be present and on time, to clean-up their own messes (of whatever nature), to respect people and the property of people. In other words, to discipline themselves so they do not become a problem for other people as well as for themselves;

10. To learn to make plans, to wait and be patient, to know that growth is a process and that set-backs can be accepted as just part of growing. I really can learn from everything if I let myself and see myself as being "in process."

Treatment and the Family

Few substance abusers can be treated in isolation. The milieu in which they live, their family life, has a strategic impact on the use and abuse patterns of abusers. Whatever treatment modality is used, the client will return to interacting with family members to some degree, whether living with them or interacting with them periodically. There is considerable literature available regarding the family dynamics related to substance abuse (Wegscheider-Cruse, 1981; George, 1990; Lewis, Dana & Blevins, 1988). The family, to some degree, contributes both to abuse and recovery or relapse. Basic patterns of interpersonal interactions are learned in one's family of origin and repeated in the abuser's nuclear family. If the interactions of the family were dysfunctional, this contributes to dysfunctional relations in later life.

The family members of the recovering abuser also affect recovery, positively or negatively. Denial of the abuse by family members may lead to their influencing the client to believe there is no "real" problem. Thus, they encourage a return to abusing behaviors. A positive, accepting attitude on the part of the family members, on the other hand, can enhance the client's chances of recovery through love and support. The counselor must realize that the family has adjusted to the client's abusing behavior in the past and the recovery of the client upsets the adjustment to some degree (Wegscheider-Cruse, 1981). It is a serious mistake to ignore the needs of the family members to be informed concerning their part in recovery.

Coexisting Disabilities

When the client possesses another disability, the impact of the family may be greater. The family members may deny that the client is abusing substances and/or may believe the level of use presents no problem. Greer (1989) pointed out that certain families may actually permit drug abuse in order to appease and, thus, manage the member with a disability more easily. Greer, Knack, and Roberts (1990) observed that in many cases, family dysfunction is present in families of persons traumatically brain injured prior to the injury. In some cases these dysfunctions result in such bizarre behaviors as family members using the individual with a disability to obtain prescription medications for the use of other family members. In the majority of cases, however, the most common and detrimental dynamic of the family members is enabling the individual to persist in the abuse of alcohol or other drugs for varied reasons.

Such families need to be confronted with the effects of their enabling behaviors in a fashion similar to that used by the "tough love" technique. The counselor must keep in mind that intervention efforts may be undermined by the family unless they are made to feel a part of the intervention effort. The enabling kind of caretaking by family members, so common in substance abuse, is very similar to that seen among families that have a member with a physical or mental disability. Out of pity, guilt, or just a need to feel of value, an important family member will relate to the "different" member in an overly protective manner. The person with the disability will not be allowed to develop in a normal way, to accept responsibility for him/herself, or to accept the consequences for his/her decisions and behavior.

This enabling and destructive behavior can be compounded when the affected family member is not only physically or mentally impaired but also a substance abuser. Sometimes a family member is instrumental in the initiating of the drinking/drug use by the disabled member

(Greer, 1989). Also, substance abuse as well as associated family dysfunction may be present **prior to** the onset of the other disability (Greer, Knack, & Roberts, 1990). This is particularly true with many cases of traumatic brain and spinal cord injuries. One comprehensive rehabilitation center estimates that around 70% of their patients with such injuries received their injuries while driving under the influence, swimming under the influence, or working under the influence. Therefore, the substance abuse might have been the disability that helped to cause the coexisting disability. Unfortunately, when it comes time to treat and rehabilitate the person for the physical condition, the substance abuse problem might be considered unimportant or ignored for a variety of reasons. Also, it is common for a physically disabled person to turn to alcohol or another drug, or increase their use, following traumatic injury.

It is very important for family members to be helped to deal with certain specific issues in cases involving both substance abuse and another disabling condition. Some of the more important issues to be considered are:

1. What does the presence of the coexisting conditions mean to the family? What are the feelings within the family about the situation? Are they ashamed? Do they feel guilty? Is it God's punishment?

2. Is the substance abuse itself acknowledged as a real and significant problem that needs specific attention? Is family counseling needed?

3. How does the family feel about the medications being prescribed for the patient as part of his/her medical management?

4. Are there family members who actually support the substance abuse by the disabled person in one way or another? Is the family aware of how it might be participating in the substance abuse?

5. Does the family seem willing to work on rethinking their attitudes toward the substance abuse, possible enabling behavior, etc.?

MODELS OF TREATMENT

Inpatient Treatment Programs

In residential programs, addicted persons live and receive treatment in a single setting. These settings can include hospital wards, free-standing treatment facilities, therapeutic communities, and halfway houses. Patients in the typical residential program spend between three to six weeks undergoing treatment. About 95% of the inpatient treatment centers use the 28-day Hazelden or Minnesota model (Langton, 1991).

Twelve step based. Although the Hazelden or Minnesota model programs are based on a variety of approaches, they are heavily dependent on three approaches to alcoholism. The first is on the twelve-step program developed by the founders of Alcoholics Anonymous (AA) and as published in the books Alcoholics Anonymous and Twelve Steps and Twelve Traditions. This

self-help program offers a framework for designing a practical treatment program and offers a life-long philosophical approach to dealing with addicting chemicals as well as general living. Typically, most twelve-step treatment programs will integrate the treatment plan with the first five steps of the AA program (see Figure IV-1 for AA steps). Modified twelve steps for persons who are deaf and traumatically brain injured are in Appendix A).

TWELVE STEPS OF ALCOHOLICS ANONYMOUS PROGRAM

Here are the steps we took, which are suggested as a program of recovery.

1. We admitted that we were powerless over alcohol and that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.

4. Made a search and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Alcoholics Anonymous, 1976, pp. 59-60

Figure IV-1

Disease concept. Alcoholism is a disease and should, therefore, not be considered as a moral problem or problem with lack of will power. The acceptance of this disease concept releases the addicted person from his/her guilt for things done prior to sobriety. It does not, however, release the person from being responsible for his/her own recovery. Most twelve step programs place the burden of responsibility for recovery on the addicted person.

The twelve steps of both AA and NA place a heavy emphasis on acceptance of a power greater than oneself. While this approach can make many persons uncomfortable and leads to images of religious conversation and the like, the acceptance of the spiritual side of treatment and aftercare is a major component of these programs. Please note that these programs make a clear separation between (organized) religion and spirituality. AA is not affiliated with any religious organization or group.

This model uses a treatment team comprised of a chemical dependency counselor familiar with AA, psychologists, physicians, nurses, recreational therapists, and clergy (Deweiko, 1990). Because addiction is a disease that affects all parts of the person's life, from his/her physical health to spiritual growth, the treatment team needs to represent several different approaches to addiction. Treatment of the chemical dependent person follows several distinct stages:

1. Each member of the team meets with the chemically dependent person to assess his/her needs from that professional's area of expertise. Each team member then makes recommendations for the patient's treatment plan.

2. The professionals meet as a team to discuss the areas that should be focused on in treatment. This meeting is chaired by the staff person responsible for the execution of the treatment process. This person is usually the chemical dependency counselor, who functions as the case manager. The team reviews the different assessments of each team member and then selects those recommendations that are most appropriate to help the chemically dependent person to achieve and maintain a drug free life. Depending on the treatment facility, the addicted person and/or the family may be a part of this process.

3. After this meeting the case manager (usually the chemical dependency counselor) and the addicted person develop a formal treatment plan. The basis for this plan are the recommendations of the treatment team; the plan contains a variety of potential treatment goals and suggestions. This plan "identifies specific problem areas, behavioral objectives, methods by which one can measure progress toward these objectives, and a target date for each goal" (Deweiko, 1990, p. 245). Each treatment goal needs to contain: "(a) a brief statement of the problem, (b) long term goals, (c) short term objectives, (d) measurement criteria, and (e) a target date" (Deweiko, 1990, p. 246).

According to Deweiko (1990), the strength of this model lies in its redundancy and the inclusion of team members from many backgrounds. The training and bias obtained from different backgrounds result in the wide assessment of the addicted person's needs. The inclusion of different professionals means that the model can offer a wider variety of services than it could with one person from one discipline. This breadth of discipline becomes even

more important if the addicted person has special needs, such as additional disabilities.

In conclusion, almost all inpatient treatment programs in the United States are based on this model. This model combines the twelve steps of AA/NA with a variety of treatment modalities such as group counseling, drug education, and confrontation of destructive thinking and behavior. (These specific techniques are explained later in this chapter.)

Psychiatric/psychological models. Although the most common model for treatment is the twelve-step model, there are other models. Psychiatric/psychological models often reject the disease concept of AODA and assume that the person drinks or uses drugs because of a psychological problem. They assume that if the person is successfully treated for the underlying problem, then chemical use will decrease and the person will either abstain or use in moderation.

This approach is the opposite of the disease concept described briefly above. While the disease concept of AODA does not deny the possibility that underlying psychological conditions contributed to alcohol and/or drug abuse, it sees addiction as a separate problem to be solved. In other words, while chemical abuse can start as a symptom of underlying psychological problems, this abuse becomes a separate disease that must be treated before any underlying problems can be dealt with. Under twelve-step programs the addiction is treated first and the other problems second. In mental health models, the psychological problem(s) is treated first. Through a variety of counseling and other techniques, the person is expected to deal with his/her psychological problems and not specifically with chemical abuse.

Spiritual or religious programs. While twelve-step programs emphasize the spiritual needs of the addicted person without pushing a specific religious belief, religious programs seek a cure by finding God through a specific set of beliefs. In addition to inpatient treatment, the following self-help groups focus on religious principles:

> Overcomes Outreach, Inc. "Christian ministry of self-help groups of persons who could benefit from a secular 12-step group in the Christian community" (Madara & Meese, 1990, p. 28).
>
> Calix Society. Roman Catholics maintaining sobriety through AA.
>
> J.A.C.S (Jewish Alcoholics, Chemically Dependent Persons & Significant Others). For alcoholic and chemically dependent Jews, their families, and their community.

Therapeutic community approaches. These long-term residential programs last anywhere from one to three years and employ "vigorous and forceful confrontation of addicts' attitudes and behavior" (Klein & Miller, 1986, p. 1083). Most of these communities focus on persons addicted to opiates or polydrug use. The philosophy of these communities is that the addicted person must be removed from his/her present environment and provided an intensive, therapeutic environment. They pursue a policy of total abstinence to all mood altering chemicals and believe that an addict (or alcoholic) is always "recovering" and never "recovered." Therefore, almost all communities provide for or arrange aftercare and follow-up services when the addicted person is discharged.

If a person has been heavily using drugs for several years and has lived in a totally drug orientated world, drastic measures are seen as necessary in order to break this pattern. The person needs to be confronted with his/her past and present thinking and behaviors, gain insight, and to literally learn how to live a new life without drugs and its accompanying deception.

Therapeutic communities use social and physical isolation, structured time, and a system of rewards and punishments. There is an emphasis on self-examination and acknowledging and confessing past crimes and wrongdoing. There is also an expectation that the addicted person work within the community. In a way these communities act as a extended family.

While therapeutic communities have been effective for some persons with very severe addiction problems, they have been criticized for their techniques, their isolation, and their lack of results. The techniques used tend to run heavily to confrontation and group criticisms of the individual. These techniques are not above criticism. For example, Ray and Ksir (1990) commented on Synanon, an early well known controversial community:

> The residents at Synanon are kept busy working. Because of a belief that addicts have difficulty in expressing emotions and in identifying others' emotions, Dederick [the founder of Synanon] established the use of 'seminars,' or encounter groups, several times a week. These encounters are often psychologically quite violent. The positive view of them is they help the addict learn to stop using destructive guards to protect himself and teach him to see himself and others more clearly. A less charitable view is that these sessions serve to threaten or cajole the new members into accepted life at Synanon. (p. 371)

While these communities do provide a drug-free environment and offer the addicted person a chance to change old thinking and behavior patterns, their very isolation prevents persons from going into the larger community to try out new social skills (Lewis, Dana, & Blevins, 1988). Finally, literature has indicated that many communities have a very high drop out rate.

In conclusion, it appears that therapeutic communities can be effective sources for treatment for persons who have failed in other treatment settings and methods. It also appears that the severity of treatment may be justified by the seriousness of the problem.

Behavioral approaches. Most behavioral treatment of addicted persons centers on the idea that an addiction is simply an overlearned behavior. As with any other behavior, changing or extinguishing addictive behaviors are subject to the "laws" and methods of operant (i.e., instrumental) and classical (i.e., Pavlovian) conditioning. Alcohol and drugs are initially used because they are reinforcing to the user. They enable the user

> ...to avoid or escape from unpleasant, anxiety-producing situations, exhibit more varied spontaneous social behavior, gain increased social reinforcement (either positive or negative) from relatives and friends, or avoid withdrawal symptoms associated with cessation of drinking. (Miller & Barlow, 1990, p. 352)

All these things provide positive reinforcement for alcohol and drug use.[1] As we all know, chemical abuse can have very negative physical, social, and financial consequences. Because negative consequences are delayed, they are not enough to prevent the behavior.[2]

The above seems to imply that all that is needed is to negatively condition the person against alcohol. However, a comprehensive model of behavioral use requires a two-fold approach: (a) techniques to decrease the immediate reinforcing properties of drug use need to be used (aversion therapy), and (b) techniques designed to provide the addicted person with behaviors incompatible with abuse must be learned. The two points of this model will be briefly discussed.

Aversion therapy is used to decrease the intake of alcohol. This therapy is based on classical conditioning that "postulates that the sight, smell, and taste of alcohol will acquire aversive properties if repeatedly paired with a noxious stimuli" (NIAAA, 1990, p. 268). There are three major types of aversion therapy: chemical, electrical, and verbal. A common chemical aversion treatment is to first administer the addicted person a chemical (such as emetine) that will cause nausea and vomiting immediately when the person drinks alcohol. Another chemical, Anectine, has been used as an aversive stimulus. An injection of this chemical will cause total paralysis. There is some confusion in the literature over the success rate of chemical aversion therapy. In many reported studies, chemical aversion treatment has been used as part of a total treatment program; this makes it difficult to determine the success of the chemical aversion treatment alone (Nathan, 1985; Wilson, 1987).

Most electrical aversion therapy uses the classical conditioning methods similar to those used in chemical aversion therapy. For example, Blake (1965; 1967) had the patient choose and mix his alcoholic drink and was told to sip and not to swallow. Concurrently, he was shocked on his forearm. To terminate the shock, he had to spit the drink into a bowl. Miller and Barlow (1990) summarized the effectiveness of this technique as follows:

> Despite the procedural advantages of electric aversion such as precise timing and control of intensity and duration, this approach has not been demonstrated superior to chemical aversion. (p. 355)

A common form of verbal aversion is called "covert sensitization"; this places emphasis on self-control. The procedure works as follows:

> Scenes leading up to drinking are vividly described. These scenes include events or thoughts which initiate the chain of drinking behavior, the setting in which drinking occurs, drinking companions, and the types of liquor consumed. After relaxation, training aversive scenes (typically sensations and nausea and vomiting)

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[1] Most of the literature reviewed for this section deals with behavior treatment of alcohol abuse. Because of this, the discussion and conclusions may not be relevant to drug abuse.

[2] In classical conditioning, the most powerful conditioning occurs when the time between response and consequence is .5 seconds.

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> are associated with all aspects of the sequence of behavior leading to drinking. Alternated randomly are scenes in which images of avoiding or refusing alcohol are associated with feelings of relief and relaxation. Patients are instructed to practice these associations on their own. (Miller & Barlow, 1990, p. 355)

As with all other treatment methods described in this chapter, research results provide a mixed picture. Although some success has been reported, methodological problems exist in most studies. The most recent NIAAA (1990) report concluded brief review of this literature by saying:

> Current research is inadequate to evaluate the potential role of covert sensitization in alcoholism therapy because most studies have not been conducted under controlled conditions. However, overt sensitization may eventually be a useful addition to broader treatment strategies. (p. 269)

The second behavioral approach focuses on teaching the alcoholic other ways of receiving the same feelings that he/she was attempting to obtain by drinking. In several studies persons were taught the use of self-controlled relaxation to deal with stress. Other researchers provided systematic desensitization to lesson social anxiety about situations in which alcoholics induced excessive drinking. The use of these relaxation techniques has been incorporated into other types of treatment programs.

A highly controversial issue related to behavioral treatment is the possibility of returning alcoholics to controlled or social drinking. The disease concept of the medical community and the philosophy and experience of AA have been clear on one major point: Alcoholism, and by extrapolation drug abuse, can only be arrested; it can never be cured. Only life-long abstinence will stop this disease that is "cunning, baffling, and powerful" (Alcoholics Anonymous, 1976, pp. 58-59). The very definition of an alcoholic is a person who loses his/her control over his/her drinking. In other words, once substance abuse starts, it cannot be stopped (Jellinek, 1990). This has been challenged by some studies that have attempted to use operant conditioning to teach social drinking to alcoholics (e.g., Helzer et al., 1985; Sobell & Sobell, 1990). As with much other research, there are serious methodological questions with many controlled drinking studies (e.g., Pendery, Maltzman, & West, 1990). In recent years this has become more of an emotional and treatment issue than a research problem.

The research has suggested that less than 2% of persons with a drinking problem might return to social drinking:

> Every alcoholic, however, would like to believe that they are in the 1-2% who might return to social drinking....one must question whether it is possible to teach the actual alcoholic to drink only on a social basis...The alcoholic who believes that he or she can learn social drinking behaviors once again, and maintain a pattern of social drinking for life, is taking a bet where the odds are at best 49 to 1, if not 99 to 1, against them...Yet many alcoholics have voiced the secret wish that they could win this bet, and land in what more than one alcoholic has called the "the lucky two percent." (Deweiko, 1990, p. 250)

Outpatient Treatment Programs

About 85% of persons receiving treatment for addictions receive such treatment on an outpatient basis. This means that the majority of addicted persons receive treatment within their own communities. Outpatient treatment can range from persons recovering only through the use of AA/NA meetings, persons seen in outpatient programs, community alcohol and drug services, and mental health centers. Except for the self help groups, outpatient treatment can be defined as a formal program that involves professionals trained to work with addicted persons using a program designed specifically for AODA and that includes family, marital, individual, and/or group therapy.

Because of the individual appropriateness, cost, and the interruption in the person's life, outpatient treatment should be seriously considered as an alternative to inpatient treatment. In making a decision between inpatient and outpatient treatment, the following should be considered: (a) motivation for treatment, (b) ability to discontinue the use of alcohol and drugs, (c) social support system, (d) employment situation, (e) medical condition, (f) psychiatric condition, and (g) past treatment history (Nace, 1987). Outpatient treatment works best with persons without an extensive prior treatment history. An additional consideration is selecting the least restrictive environment given the addicted person resources and needs.

Outpatient treatment programs have some advantages over inpatient programs. Outpatient programs cost less and do not remove the person from his/her environment; this means that no community reorientation program is needed. If the outpatient program is of long duration (e.g., 6 to 12 months), it will offer the long-term follow-up that is needed during the first year of sobriety. Finally, outpatient programs are seen as being more flexible. This section will briefly describe the following outpatient treatment settings: AA/NA, methadone maintenance, outpatient drug free programs, occupational alcoholism programs, and work place based programs.

AA/NA. Founded in 1935, AA is the oldest and largest self-help group in the United States. Started by a stockbroker and physician, its goals are to help persons get sober, to help them to maintain sobriety, and to "carry the message to other alcoholics who still suffer" (Alcoholics Anonymous, 1976, p. 60). The AA program and philosophy is to be found in the twelve steps (see Figure IV-1). These twelve steps originated in the Oxford Movement, a non-sectarian Christian movement popular at the time of the founding of AA. One analysis of the twelve steps classifies them as follows:

> The first three steps are viewed as necessary for accepting one's limitations. These steps serve to help the individual realize that he/she cannot deal with life totally alone, especially in making major changes.
>
> Steps four through nine are a series of change orientated activities. These steps are designed to help the person identify, confront, and ultimately overcome character defects that are a major part of the person's addicted lifestyle. Using these steps allows the person to work through the guilt associated with addictive behavior and to accept the limits of personal responsibility. Most important, they allow the person to learn the social and personal tools of drug free living.

> Steps ten through twelve challenge the person to continue to build on the foundation established in steps four through nine. Here the person is urged to carry out personal shortcomings and deal with them in a way consistent with the AA program. Finally, the person is urged to continue spiritual growth and to help other persons with the same problems. (Deweiko, 1990, pp. 282-283; Al-Anon Twelve Steps and Twelve Traditions)

Narcotics Anonymous (NA) was started in the early 1950s by drug addicts who felt they needed a separate program designed specifically for them. NA uses the same twelve steps as AA. Although AA and NA may cooperate, they are not affiliated.

In dealing with AA and NA as a treatment modality, we are really dealing with three separate functions that occur simultaneously. First, AA/NA acts as basic treatment. Before there were the wide variety of professional chemical dependency services that are available today, persons joined AA/NA in hopes of becoming and maintaining sobriety. AA/NA still continues to perform this basic treatment function today for some persons. Second, these two organizations can be used in conjunction with inpatient and outpatient treatment. A common outpatient plan includes regular attendance at one or more AA/NA meetings per week. This lends additional support to the person during outpatient treatment and enables him/her to build a support network that will function after treatment has ended. Finally, AA/NA provides a method of aftercare for persons coming from inpatient treatment. Most discharge plans attempt to build a network of support around the newly recovering person; AA/NA is often a critical part of this network. If properly used, AA/NA can provide life long support.

The typical AA/NA closed meeting is held at the same time and day of the week and lasts one hour. The format of the meetings differs with the traditions of local groups. In one format the meeting is opened with reading the twelve steps, and a topic or issue for discussion is selected by the meeting leader. All persons at the meeting speak in turn about this topic or any problem that they are presently encountering. Persons not wanting to speak can pass. After all have spoken or passed, the meeting ends with a minute of silence.

As with other treatment methods, the question arises "How effective is AA/NA?" As elsewhere, the literature provides only partial answers. Since AA is the major self-help group for addictions, since it is the oldest, and since most inpatient and outpatient treatment is based on the twelve steps, it must be effective for many persons. If the literature can be summarized into a single statement, AA/NA are effective if the person has the desire to remain drug free, if he/she attends meetings regularly, and if he/she follows the program in his/her daily life. Like all other treatment modalities, AA/NA success is heavily dependent on the person's motivation to live without addicting chemicals.

Methadone maintenance. Methadone is a synthetic narcotic developed by the Germans during World War II as a substitute for unavailable opiate-based pain medications. In the United States it is commonly used in the treatment of heroin addicts. The basic theory is that persons addicted to heroin and other narcotics will never abstain from narcotic use. Therefore, if supplied with these drugs legally, they could at least partially recover and reduce their criminal activity. Methadone is longer acting than heroin and its withdrawal symptoms are less severe (Ray & Ksir, 1990). In addition, it blocks euphoric effects of injected narcotics. However,

while the person does not desire narcotics, this treatment approach does not restrict the use of alcohol and other drugs.

The basic idea is that heroin addiction is a very expensive addiction to support and that, as with other drugs, the addicted person centers life around obtaining, using, and recovering from using the drug. If the addicted heroin addict is maintained on a legal drug, this would reduce illegal acts committed to obtain the money to purchase the drug and would free up time to devote constructive nondrug related activities. Early studies on methadone maintenance found that it does reduce criminal activity among participants.

In the typical methadone maintenance program, the addicted person reports to a clinic several times a week to receive the drug. Sometimes "treatment" consists only of handing out methadone. Methadone maintenance programs should be only one component of a program that involves: (a) no use of any other drug or alcohol, (b) counseling and other services to help the addict develop insight and social skills, and (c) vocational components to encourage economically productive skills. Effective programs combine these elements into a unified treatment program.

There is a basic philosophical problem with methadone maintenance programs. On one hand, almost all persons in the chemical dependency field as well as state and federal policies have the goal of promoting drug abstinence. Methadone clinics supply persons with an addictive substance; this goal appears inconsistent with abstinence practices.

Outpatient drug free programs. Persons who receive outpatient treatment can often receive services during the normal working day or in the evening. In a day program the person goes to treatment during normal working hours. This has the advantage of providing structure to the person's life, especially if he/she is not employed. Evening treatment programs obviously occur after the normal work day and are usually designed for persons who are employed. Evening programs enable the person to keep a job and still receive structured help for chemical dependency.

"Services range from drop-in 'rap' centers to more formal psychotherapy, group counseling, vocational counseling, and other professional services" (Ray & Ksir, 1990, p. 373). As with inpatient treatment, most of the programs follow the AA/NA twelve-step model and include a variety of treatment modalities: group counseling, family therapy, and progress through the first five steps of AA/NA. During the time of the program, the addicted person is expected not to use any mood altering chemicals. Some programs put some teeth in this requirement by obtaining random urine analysis tests.

As stated above, because outpatient treatment does not require that the person leave the community, it does not seem to be as big a step as inpatient treatment. Therefore, it appeals to persons stopped early in their addiction careers.

Employee assistance programs. One of the truisms in chemical dependency treatment is that a person might not stop abusing chemicals to save a marriage, family or even his/her home, but will stop to save his/her job. Maintaining a job is often the last link of respectability for the person. As with other outpatient programs, the person does not have to leave the family and job.

Companies are motivated by a loss of profits and cost containment. The annual costs of worker drug abuse to employers is $60 billion, including health care costs, lost productivity, and accidents (Backer, 1987). The military, government, and large companies have established employee assistance programs (EAP) to cope with addicted members of their work force, as well as other employee problems. These programs must go far beyond random drug testing and "detox and off to AA" (Backer, 1988, p. 39). Most of these programs operate on five principles:

1. The company makes it plain that it considers alcoholism as a disease and will treat alcoholics just as it does employees with any other disease;

2. Supervisors are told to report poor job performance, often the first indicator of alcoholism, to trained counselors in medical or personnel units;

3. If the problem is diagnosed as alcoholism, the employee is given the choice of entering a treatment program or losing his job for poor performance;

4. A worker who enters treatment gets sick leave and medical benefits; and

5. Medical records of alcoholism are kept confidential. (Ray & Ksir, 1990, p. 365)

EAP alcoholism and drug abuse programs usually pay back the employer in reduced accidents, increases in efficiency, and less sick leave.

COMMON ELEMENTS USUALLY FOUND IN AODA TREATMENT

The last section described a variety of inpatient and outpatient treatment modalities. Most common inpatient and outpatient treatment methods are those derived from the Minnesota or Hazelden model, which includes heavy use of AA/NA beliefs and values. Within these various treatment settings, a variety of specific techniques are used to help the addicted person change. Some of these methods are common to a variety of helping professionals; others are more unique to the treatment of AODA. Following are the most common methods briefly defined.

Group Sessions

Group sessions are often held both with and without a counselor. In both, the addicted person is encouraged to bring concerns to the group. Group therapy sessions have three advantages over individual therapy: (a) they allow the counselor to work with many different clients at one time; (b) the clients can learn from each other; and (c) some members would find the groups to be a reflection of the family or origin, allowing the person to work through problems from earlier stages of development.

Group sessions are also held without a counselor present. These permit group members a safe place to try out new behaviors and thinking and to begin to learn how to function in a self-help group. Group sessions are the mainstay of both inpatient and outpatient AODA

treatment programs. A typical inpatient program may hold several group sessions each day.

Promotion of Abstinence

With the possible exception of some behavioral and psychological approaches to addiction, almost all counselors, researchers, and policy makers promote total abstinence from all mood altering chemicals. This is based on the loss-of-control concept, the idea that addiction disorders can only be arrested--never cured--and clinical observations that the vast majority of addicted persons never can return to moderate social drinking or using. This promotion of abstinence underpins all group counseling and most other treatment activities. However, other programs teach the addicted person that they only have to refrain from using or drinking only one day at a time. This philosophy encourages refraining from drinking or using only "one day at a time," rather than requiring commitment to life-long abstinence.

Confrontation of Destructive Thinking and Behavior

In confrontation, the addicted person is plainly and clearly told what past behavior led to unwanted consequences. Confrontation is often necessary to break through the wall of denial and self-deception created by the addicted person. In confrontation, the addicted person is shown clear evidence of what abuse of chemicals has caused. Members see the financial, family, vocational, personal health, and social consequences of their behavior. During intervention and early in treatment, this method is often used to a considerable degree. One common criticism of AODA counselors is their overuse of confrontation. While the technique is needed, it should not be the only technique used by counselors.

Encouragement to Recognize and Verbalize Feelings

One of the most common personal problems in addicted persons is their lack of ability to know their emotions and to state what they feel. Alcohol and drugs are called "mood alternating" chemicals for very good reasons. Many addicted persons began in the first place to drink or use because they were uncomfortable with or afraid of their emotions. As drugs and alcohol are ingested they can both mask underlying emotions or create false feelings. Addicted persons often do not know what they feel; they only know they hurt upon entering recovery.

Because of these problems, AODA persons need to be taught to read their own minds and bodies for their true feelings. Once they have identified anger, guilt, love, compassion, etc., they have to learn to express these feelings verbally. Knowledge of and expression of emotions are two of the more common goals of many treatment programs.

Support to Deal Directly with Troublesome Relationships

Everyone not living alone in a forest has to live and interact with other persons. Addicted persons, like the rest of us, have parents, siblings, spouse(s), and children. Most have (or had) friends and a host of relationships in the employment setting. One of the most common problems of alcohol and drug abuse is that the person isolates him/herself from family and friends. As the addictive chemical(s) become the center of life, there is little or no room for other persons.

The person rationalizes the use of chemicals by saying that he/she is unloved, not appreciated, taken advantage of, or not respected. When the person begins to recover, he/she begins to realize that he/she caused considerable damage to the persons closest to him/her. This is why alcoholism is often called a "family disease" and why treatment will sometimes emphasize family and martial therapy.

> Individuals who are addicted to chemicals often lack the ability to assert themselves, and could benefit from [assertiveness] training in this vital skill. Many programs offer an assertiveness training component to clients who are thought to be in need of remedial training. (Deweiko, 1990, p. 258)

Drug Education

At one level, persons who abuse drugs and alcohol are very much aware of what these chemicals do to the central nervous system. Beyond this level, they may not know what the long-term or side effects of a single drug will be, let alone the interaction effects of polydrug use. Part of treatment is often an introduction of the various chemical substances and how they affect mind and body. Sometimes drug education also includes nicotine and caffeine. This is intended to provide the person with a source of unbiased information that can be used to make future rational choices.

Suggestions of Healthier Choices Open to the Person

An addicted person's main response to tension, anxiety, inferiority, etc., is to take more of the addictive substance(s). If persons can be shown in treatment that previous choices were unhealthy, then they may learn some new, healthier choices. For example, instead of drinking to relax after work, go for a walk or relax with a book or friends. If the person feels tense and afraid about some personal problem, talk with a friend or meditate. In some treatment programs, relaxation techniques and other tension reducing methods are taught as healthier choices. Suggestions for making healthier choices can run the range from personal nutrition to changes in career and ending long-term relationships.

Encouragement to Become Responsible for One's Own Life

Addicted persons have made a series of bad choices that have not only resulted in their addiction but also resulted in financial, family, vocational, and personal disasters. Part of treatment will commonly have the AODA person review his/her life, analyze how some major decisions were made, and learn how to become more responsible for his/her own life. Personal responsibility is one of the keystones in many twelve-step treatment programs. The addicted person might not have been responsible for becoming addicted but is taught to be responsible for life from treatment on. This means making responsible decisions, accepting that there are some situations that are completely beyond their control, and accepting the consequences of these decisions.

AFTERCARE OR MAINTENANCE THERAPY

This phase of treatment can be as long as a year, two years or ten years. Attendance at

Alcoholics Anonymous or Narcotics Anonymous meetings and involvement in the program's twelve-step structure might continue for the rest of one's life.

For those who go to a residential center, this phase begins at discharge from that program. For those who have used an intensive outpatient program, it begins after a few weeks of more intensive and probably daily therapy sessions. During the maintenance phase, the person probably is back into his/her normal schedule of activities. This is the time when these persons begin to integrate what they have learned in the more intensive treatment into their daily lives. They use their daily living experiences as problems to be dealt with in their continuing therapy sessions. As the cycle of continuing therapy and daily living continues, the person learns to respond to true feelings and the demands of daily living in a healthier manner. They draw on internal resources, new support, and insights into themselves.

The automatic, nonthinking tendency to turn to the drug of choice under stress diminishes and then gives way to an awareness of healthier choices and to an increased ability to make use of those choices. The person gains confidence in his/her ability to be around those who drink and/or use other drugs without feeling that they must participate.

Remember that treatment for addiction is not a quick fix and that abusers are having to face and learn to deal with an array of chronic problems and situations. Many of these problems did not appear at first to be related to their drinking or drug use.

The counselor should always remember, especially when client progress seems slow or erratic, that the client is not just trying to stop use of a drug, but is involved in the restructuring of deeply ingrained emotional and relational responses of the personality. Much practice of new living skills is necessary to assure true growth and stability. By continuing to be available to the client throughout some of these growing pains, the rehabilitation counselor provides a very valuable supportive service. There should be continuing encouragement and redirecting of the client back to treatment when things get rough. This function of the counselor is not unlike what they provide for clients going through arduous rehabilitation efforts following traumatic physical injury.

During the days of aftercare, there will be times when the task of maintaining sobriety or drug-freeness is very difficult. For a counselor or anyone else to deny this or to adopt a stance of glib, nonempathetic optimism is not supportive. However, if a client can accept that continuing therapy is needed and that using it on a regular basis is not a sign of weakness but strength (as acceptance of reality always is), he/she will have chosen an attitude that leads to success in treatment. There are no quick, easy, simple, painless cures, but treatment definitely works.

Treatment is a process having a beginning and various phases, but not necessarily an ending. Those who use it seriously and well do not wish for it to end. For them, it becomes or merges into the process of life, itself. They simply continue growing and continue enjoying being in charge of their own lives.

MULTICULTURAL ISSUES

Multicultural issues are important considerations for providers of Vocational Rehabilitation. A significant percentage of clients to VR are made up of members of ethnic minorities or people of color, including African/Americans, Native Americans, Asians/Pacific Islanders, and Hispanics. In fact, within the next generation, most major metropolitan areas will be predominantly populated by people of color. Current thinking in the field of substance abuse treatment recognizes the importance of understanding why ethnic minorities and people of color become substance abusers and substance dependent. The Office of Substance Abuse Prevention (OSAP) provides three questions to help understand issues of causation:

1. What is the historical and social significance of alcohol and drug abuse within communities?

2. What are the specific cultural norms, beliefs, and values which foster and counter drug abuse?

3. What are the societal and institutional forces which have implications for drug abuse in ethnic minority communities? What are the primary institutions of support?

The essence of treating substance abuse and dependence problems for members of ethnic minorities or people of color involves the traditional educational approach. It also teaches the negative consequences of substance dependence, and deals with psychosocial and emotional issues that embrace the life styles, physical characteristics, cultural attitudes, beliefs, norms, values, and traditions of ethnic minorities or people of color. For example, one of the strongest predictors of African/American males becoming drug involved is the stressors they experience due to their race and racism (Harper, 1975). Hispanic kids can be predisposed to drug involvement due to a lack of English fluency which results in difficulty identifying with the model culture, producing barriers to friendships and leading to discrimination from members of the model (English-speaking) culture (Collado-Herreel, 1980). Native American children and adolescents have a propensity to be linked to drugs due to their feelings of powerlessness, a powerlessness which is attached to their ethnicity (Tremble et al., 1983).

In order for the vocational rehabilitation counselor to provide quality services to persons with coexisting disabilities, he/she must be sensitive to the needs of these individuals. Research has shown a definite link between ethnic membership and cultural influences on drinking and other drug abuse (Drug Free Schools and Communities, Vol. 2, Issue I, 1988). A common error many persons make is thinking only the uneducated and mean spirited are bigots. However, prejudice is as much a part of all cultures as are love and kindness. All of us are in some way biased/prejudiced in favor of members of our own racial and cultural group. We tend to value our lifestyle and reject others. We are particularly prone to be influenced by stereotypes when we meet strangers of other racial/cultural groups. The stereotypes that surround race and skin color are some of our most persistent and inaccurate images. The term "race" lacks scientific validity and has no value in predicting behavior.

Members of ethnic minorities have their particular coping styles based on their life experiences, learning styles, socialization, and conditioning just as members of the majority

group fashion their coping styles and adaptation. For example, people of color can be, and often are, traumatized by their life conditions. These life conditions include such things as lower socioeconomic conditions, lower societal acceptance and expectations, oppression, and racism. The impact of these conditions is often internalized by the ethnic group member, resulting in viewing these conditions as his/her fault. This is analogous to adult children of alcoholics feeling and believing that their loved one's alcoholism is somehow their own fault. When ethnic members take ownership for conditions such as racism and socioeconomic status, both their self-esteem and self-concept are adversely impacted. Strong internalized hopelessness and powerlessness lead to decreased efforts to strive for positive identification, competence, positive coping, and health orientation (Bell, 1990).

Those who work with ethnic minorities can give them optimum treatment experiences when the methods used are presented from the clients' cultural context. Cultural context treatment, along with increasing learning, has a powerful ability to develop self-esteem and self-concept. Service providers need to have a healthy sensitivity to the members of the groups being served. The Research Center at Georgetown University outlines the following considerations for service providers:

1. Acceptance of ethnic differences among people;

2. A willingness to work with clients of different ethnic groups;

3. Clarification of one's own values, stereotypes and biases;

4. Personal commitment to change racism and poverty and other negative life conditions;

5. Knowledge of the impact of class and ethnicity on behaviors, attitudes, and values;

6. Knowledge of the role of languages, speech patterns and communication styles in ethnically distinct communities;

7. Knowledge of ethnic resources; and

8. Recognition of one's own values and how they may conflict with or accommodate the needs of ethnic minorities, ability to openly discuss racial stereotypes and myths in individuals and institutions and resulting impacts.

There are many complex issues regarding racial and ethnic diversity. To avoid over-simplification, no attempt will be made to detail the differences in these groups that impact on counseling techniques. However, the reader is directed to the 1992 IRI cycle which will explore in depth multi-cultural issues in rehabilitation. A further resource is Chemical Dependency and African-American: Counseling Strategies and Community Issues (Bell, 1990).

REFERENCES

Al-Anon's twelve steps and twelve traditions. (1985). New York: Al-Anon Family Group Headquarters, Inc.

Alcoholics Anonymous. (1976). (3rd ed.). New York: Alcoholics Anonymous World Services, Inc.

Alcoholics Anonymous. (1952). Twelve steps and twelve traditions. New York: Alcoholics Anonymous World Services, Inc.

Backer, T. E. (1987). Strategic planning for workplace drug abuse programs. Rockville, MD: National Institute on Drug Abuse.

Backer, T. E. (1988). The future of rehabilitation in the workplace: Drug abuse, AIDS & disability management. Journal of Applied Rehabilitation Counseling, 19(2), 38-40.

Bell, P. (1990). Chemical dependency and African-Americans: Counseling strategies and community issues. Drug Free Schools and Communities, 4, (1).

Blake, B. G. (1965). The application of behavior to the treatment of alcoholism. Behavior Research and Therapy, 3, 75-85.

Blake, B. G. (1967). A follow-up of alcoholics treated by behavior therapy. Behavior Research and Therapy, 5, 89-94.

Brown, S. (1985). Treating the alcoholic: A developmental model of recovery. New York: John Wiley.

Chafetz, M. E. (1990). Is compulsory treatment of the alcoholic effective? In D. A. Ward (Ed.), Alcoholism: Introduction to theory and treatment (pp. 272-280). Dubuque, IA: Kendall/Hunt Publishing Co.

Collado-Herreel, L. L. (1980). Prevention and Ethnicity and Current Research.

Commerce Clearing House. (1990). Americans with Disabilities Act of 1990: Law and explanation. Chicago: Author.

Deweiko, H. E. (1990). Concepts of chemical dependency. Pacific Grove, CA: Brooks/Cole Publishing Co.

George, R. (1990). Counseling the chemically dependent: Theory and practice. Englewood Cliffs, N.J: Prentice Hall.

Greer, B. (1989). Alcohol and other drug abuse by the physically impaired. Alcohol Health and Research World, 13(2), 144-148.

Greer, B. G., Knack, M. A., & Roberts, R. (1990). Family dynamics in traumatic head injury. In C. Long, L. Ross, & M. Munchkin, (Eds.), Traumatic head injury: A re-examination. New York: Plenum Press.

Harper, F. (1975). Prevention and Ethnicity and Current Research.

Helzer, J. E., Robins, L. N., Taylor, J. R., Carey, K., Miller, R. H. Combs-Orme, T., & Farmer, A. (1985). The extent of long-term moderated drinking among alcoholics discharged from medical and psychiatric treatment facilities. The New England Journal of Medicine, 312, 1678-1682.

Holden, C. (1987). Is alcoholism treatment effective? Science, 236, 20-22.

Jellinek, E. M. (1990). Phases of alcohol addiction. In D. A. Ward (Ed.), Alcoholism: Introduction to theory and treatment (pp. 17-28). Dubuque, IA: Kendall/Hunt Publishing Co.

Johnson, V. E. (1986). Intervention, how to help someone who doesn't want help. Minneapolis: Johnson Institute Books.

Klein, J. M., & Miller, S. I. (1986). Three approaches to the treatment of drug addiction. Hospital and Community Psychiatry, 37, 867-872.

Langton, P. A. (1991). Drug use and the alcohol dilemma. Boston: Allyn and Bacon.

Lewis, J., Dana, R., & Blevins, G. A. (1988). Substance abuse counseling: An individualized approach. Pacific Grove, CA: Brooks/Cole.

Madara, E. J., & Meese, A. (Eds.) (1990). The self-help sourcebook: Finding & forming mutual aid self-help groups. Denville, NJ: Saint Clares-Riverside Medical Center.

Miller, P. M., & Barlow, D. H. (1990). Behavioral approaches to the treatment of alcoholism. In D. A. Ward (Ed.), Alcoholism: Introduction to theory and treatment (pp. 352-364). Dubuque, IA: Kendall/Hunt Publishing Co.

Nace, E. P. (1987). The treatment of alcoholism. New York: Burner/Mazel.

National Institute on Alcohol Abuse and Alcoholism. (1990). Seventh special report to the U.S. Congress on alcohol and health. Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration.

Nathan, P. E. (1985). Aversion therapy in the treatment of alcoholism: Success and failure. Annals of the New York Academy of Science, 443, 357-364.

Pendery, M. L., Maltzman, I. M., & West, L. (1990). Controlled drinking by alcoholics? In D. A. Ward (Ed.), Alcoholism: Introduction to theory and treatment (pp. 384-396). Dubuque, IA: Kendall/Hunt Publishing Co.

Price, J. (1988). Alcohol screening and early intervention: An achievable advance in management. Medical Journal of Australia, 149, 346.

Ray, O., & Ksir, C. (1990). Drugs, society, & human behavior (5th Ed.). St. Louis: Times Mirror/Mosby, College Publishing.

Sobell, M. B., & Sobell, L. C. (1990). Alcoholics treated by individualized behavior therapy. In D. A. Ward (Ed.), Alcoholism: Introduction to theory and treatment (pp. 364-383). Dubuque, IA: Kendall/Hunt Publishing Co.

Tremble, et al., (1983). Researchers for NIDA. Prevention and Ethnicity and Current Research.

Wegscheider-Cruse, S. (1981). Another chance: Hope and health for the alcoholic family. Palo Alto, CA: Science and Behavior Books

White, J. M. (1990). Drug dependence. Englewood Cliffs, NJ: Prentice-Hall.

Williams, F., & Knox, R. (1987). Alcohol abuse intervention in a university setting. Journal of American College Health, 36, 97-102.

Wilson, G. T. (1987). Chemical aversion conditioning as a treatment for alcoholism: A re-analysis. Behavior Research and Therapy, 25, 503-516.

Chapter V

THE ROLE OF THE REHABILITATION COUNSELOR IN THE NETWORK OF COOPERATING AGENCIES

The rehabilitation counselor who is just beginning to work with substance abusing clients, without any significant amount of orientation or training in the field of addiction, may wonder exactly what he/she is supposed to do. Phrased differently, the counselor may be unclear as to what he/she has to offer the addicted client. Guidelines provided by the counselor's own agency may seem very restrictive or too general. Counselors often must deal with their own personal feelings toward substance abusers and how legitimate they feel addiction is as a disability deserving of services.

COUNSELORS' RESPONSES TO SUBSTANCE ABUSING CLIENTS

Persons who are new to serving persons with substance abuse as a disability are prone to making errors. Listed below are the common pitfalls of working with this population:

The Error of Buying for and Doing for the Consumer

Many counselors approach the task of serving the abusing clients with the attitude that these consumers are weak, rather helpless persons who need a lot of things done for or to them. Since the client has a disease that has taken away will power, judgment, motivation, and ability to manage, nothing much should be expected of the client (such as coming for appointments on time and sober). In addition to these factors, the client may be quite charming or seductive.

The counselor may see the addicted client as a person deserving of pity. The counselor's response may be to do as many things as possible for the client and to tolerate relatively abusive behavior on the client's part. Since many substance abusers are quite adept at manipulating the system (and individuals) to get what they want, the inexperienced counselor may be enticed into dispensing education, training, tools, uniforms, and whatever else the client might suggest that (in their opinion) will keep them sober or off drugs.

The Error of Overly Managing the Consumer

Short of the above extreme, but related to it, are counselors who are kindhearted and caring. They feel that they must figure out what is wrong with consumers, their needs, and then recommend every possible service that may be needed. This counselor is a prescription writer. The rational is that the consumers are not capable of contributing much to the rehabilitation process, so the knowledgeable counselor must take charge and manage things for them.

Another counselor might not buy a lot of things for consumers. This counselor assumes or acts as though the primary responsibility for the clients' rehabilitation is the counselor's, not the clients'. Such a counselor is setting him/herself up for disappointment. These consumers

will tend to cooperate with the counselor's perceived role and not give much energy to their own rehabilitation. Clients in such a relationship often make unrealistic demands of their counselors, expecting inappropriate services and blaming the counselor when their rehabilitation falters. The counselor should not accept the clients' responsibilities.

Unrecognized dependency is a distinguishing characteristic of substance abusing persons. It extends beyond dependency on the drug of choice to a general dependency on some power outside themselves. Many will want someone to be there for them, to be a kind of safety net for the decisions they make or fail to make. Such dependency easily transfers from the drug to a person. This is especially true regarding a person such as a counselor who is offering him/herself as a service provider to help people. Counselors need to be sensitive to this dependency and not allow their clients to use it to manage and manipulate them.

The Error of Judging the Consumer

A third type of counselor response to substance abusers is resistive or even punitive. These counselors have strong personal feelings against such clients. These counselors may have had to deal with a substance abuser in their own families and therefore believe they "know all alcoholics lie." As a result, either they do not want to work with this population at all or, if they must serve persons with substance abuse as a disability, they convey to the clients a lack of acceptance and a scolding or critical attitude. Consumers with coexisting disabilities typically already suffer from low self-esteem. Counselors with this attitude will come across as a critical parent and not as therapeutic advisors. Such counselors will tend to deny clients with substance abuse disabilities the time, energy, and information needed for their rehabilitation.

The Error of Working Alone

It has been common for some rehabilitation counselors to work by themselves with addicted clients, accepting such cases as "Counseling and Guidance" cases. Traditional direct counseling is provided by the counselor in addition to standard vocational evaluation and adjustment services. In some cases, plans might include vocational training and assistance in job placement. The client is kept within the agency and receives no treatment at all from any service provider especially trained and experienced in addiction treatment. The client might not have been diagnosed as a substance abuser. Some professional diagnosticians are reluctant to write such a diagnosis, or they consider it to be secondary to another diagnosis and hardly worth mentioning by name.

A person with a coexisting disability served in this manner might not have received any real help in facing the addiction. Many such cases are closed as unsuccessful by frustrated counselors who tend to decide after a few such attempts that nothing can be done for addicted people. Oftentimes the attitude is that some clients just "drink too much" because they do not like their jobs. The assumption is if the counselor works toward securing a different job for the client, the client would have no need to drink and a successful closure could be obtained.

COUNSELING THE SUBSTANCE ABUSING CLIENT: A SUGGESTED COUNSELOR FRAME OF REFERENCE

Substance abusing clients need a counselor who is available, though on the counselor's own terms. Appointments should be given with some degree of frequency, perhaps once per week, though not necessarily for a long session. Every effort should be made by the counselor to involve clients in decision making at every step of the rehabilitation process and to expect clients to accept primary responsibility for their rehabilitation. The counselor should be a good listener, helping the clients "hear" what their own attitudes and perspectives are (as reflected back by the counselor). Substance abusing persons need to know how they sound, appear, and are experienced by other persons. They need to learn what kinds of feelings other people have when in their presence. The counselor can provide that valuable service by being direct and honest with the clients about the way they come across to the counselor.

Substance abusers tend to blame other people, in one way or another, for the problems they have. It is easy for them to slip into that stance with the counselor, expecting the counselor to almost magically make life better for them. They may show disappointment when offered services that are not what they expected, do not work as quickly as expected, or require effort. The counselor needs to be aware of this reaction and not be overly affected by the criticism of the clients. It is helpful for the counselor to have a clear understanding with the clients very early in the rehabilitation process as to what services will be offered. The counselor needs to convey what will be expected of the clients and what the clients can expect of the counselor.

It is very important for the counselor to be very open and direct with the client and to invite the same from the client. Holding back in communication between counselor and client is especially destructive with substance abusing persons. The counselor should avoid being so nice that communication becomes unclear. Over concern for feelings often causes communication to become so foggy that expectations are heard as suggestions. If the counselor will take the lead and set the tone for communication early in the process, being straightforward with the client at all times, the client is more inclined to take this as permission to do likewise with the counselor. Such open and honest communication should lead to a more effective and honest partnership.

An Example

One rehabilitation counselor in South Carolina, known for his number of successful closures of substance abuser cases each year, is also known for his candor, even bluntness in relating with his clients. In most cases, he will not talk with a substance abuser applicant regarding rehabilitation services until the client has been to his office, sober, for two or more interviews and has been to several AA and/or NA meetings (the schedule for which is given to the applicant by the counselor at the time of the first interview). It is made very clear by the counselor that motivation and effort on the client's part must be demonstrated before feasibility is established as part of the eligibility determination process. Keeping interview appointments is therapeutic for the substance abuser. During these interviews the counselor obtains a vocational and personal history. The counselor sets the tone for their work together by his direct questions, responses to client questions, and by his refusal to simply do things for the applicant.

The counselor makes it clear that he has no power to change the applicant or make his/her life different in any way, that the applicant must be the one who decides what his/her problems are and what he/she wants to do about them. The counselor is there to consult with, to make the applicant aware of the choices open to him/her, to provide information, and to refer to services that seem appropriate. Also, the counselor is there for encouragement, support, confrontation, and reality testing by the applicant.

If the applicant follows through with the initial plan outlined by the counselor, goes to AA or NA meetings, and keeps appointments with the counselor, the counselor then discusses further treatment needs with the applicant and accepts the applicant onto the caseload, writing a rehabilitation plan that includes treatment on either an inpatient or outpatient basis. Actually, all clients who go for inpatient treatment will be required to follow-up with an outpatient program after inpatient discharge. This counselor never considers inpatient therapy or a several-week outpatient program as complete treatment.

He conveys that therapy for substance abuse should be thought of in terms of years, not weeks or months. However, the vocational rehabilitation case may be closed successfully long before treatment ends, with the client back at work and functioning. This counselor believes good treatment for addiction deals with more than the substance abuse. It also deals with personal and relational issues in the client's life, marital and in-law problems, early childhood matters, relationships with parents and significant others, and other problems. Those issues might appear in the beginning to have little or nothing to do with the addiction. However, they must be dealt with if the person is to truly recover. The counselor can help the client to accept the need to deal with such issues, even though the counselor probably will leave to the treatment professionals the task of actually doing this work.

VOCATIONAL REHABILITATION COUNSELOR VALUES

The rehabilitation counselor should remember that he/she is primarily a vocational rehabilitation counselor, not an addiction treatment counselor. The rehabilitation counselor has much to offer such clients by staying within the role of a vocationally oriented professional. The counselor should never feel that his/her value to the client is somehow secondary to other treatment professionals. Substance abuse treatment personnel, usually, are not very interested in the vocational aspect of a client's life. Rarely are these persons skilled in discussing or helping a client make realistic vocational plans. It is very important that rehabilitation counselors be convinced they have unique value in the recovery/rehabilitation process. They should feel free to offer to the client (and the treatment staff) vocationally related expertise. As rehabilitation counselors continue to talk with treatment personnel, they will become aware of what each has to offer, will gain respect for each other's role, and will not get in each other's way in their work with mutual clients.

Guidelines, then, begin to emerge from this discussion of the rehabilitation counselor's role:

1. Expect the client to think, make decisions, and take action in his/her behalf;

2. Talk very honestly and candidly with the client;

3. Expect healthy, sober behavior from the client. If he/she comes to your office for a scheduled interview under the influence, tell him/her you cannot perform your task under those conditions and that you will see him/her again at a future time, sober (straight);

4. Set limits on what you will/will not do for the client and the terms under which you will be available to him/her;

5. Let him/her know that continuation in treatment is essential to the continuing of Vocational Rehabilitation services. This is not a negotiable item. Treatment is a must, not a maybe; if the client gets any other message regarding treatment, the Vocational Rehabilitation counselor has become a destructive influence in the client's life; to support treatment is one of the basic aspects of the Vocational Rehabilitation counselor's role;

6. Let the client know from the start those actions that will cause the Vocational Rehabilitation case to be closed or placed in suspension; a relapse to drug use should normally not close a case, since relapses can be useful in helping a client to accept the severity of his addiction and draw attention to issues in his/her life that need closer, harder therapeutic work; a relapse for a client who is staying involved in therapy can be simply part of the recovery process, and counselors should not react negatively to such happenings; and

7. Let the client have his/her own feelings about the relapse, while the counselor continues to be available and directs the client back to the therapy program in a matter-of-fact kind of way. On the other hand, if the client drops therapy and makes it clear that he/she does not plan to resume, this action will justify closure of the case or temporary suspension.

Through the years, some rehabilitation counselors have defined their role as a purchaser/coordinator of services, job placement person, and/or vocational counselor. On occasion the emphasis is more on "counselor" than "vocational." With addicted clients, the purchasing of services becomes (usually) the least important of services. The substance abusing client is usually inexpensive in terms of money spent on tangible services, but expensive in terms of counselor time and energy. It is the person as "counselor" who becomes most important with addicted clients. It requires the ability of the counselor to sit with the client and listen, to give honest and direct feedback, and to represent the standards and expectations of the everyday world of work. It also requires being a caring, reality-oriented person, and one with whom the client can relate on a regular basis. Through such a relationship the consumer can begin to experience what it's like to be among non-addicted workers in our society.

The following is a partial list of services that a vocational rehabilitation counselor can offer an addicted client:

1. Time and availability--someone who will return calls and not unduly hurry interviews and counseling sessions;

2. The ability to listen without judging, without trying to change the client, and without trying to assume responsibility for him/her;

3. Educated and informed (trained) compassion and emotional support, which is different from enabling sympathy;

4. Awareness of choices that the client might not see;

5. Orientation to reality, to an ordered, disciplined and responsible way of life, which is communicated to the client;

6. The use of him/herself as a "sober" model, a "straight" authority figure;

7. Ability to set limits to which the client is invited to adjust;

8. Personal warmth and humanity, along with firmness;

9. An evaluation of the client and the sharing of evaluations done by others (and interpreting of those evaluations);

10. Honesty and directness; ability to confront potentially destructive thinking or behavior on the part of the client;

11. Awareness of information and other services which can be useful to the client; and

12. Encouragement to the client to become a more self-directed "free" person who wants to live in a responsible and productive community with others.

It is not intended that services such as vocational training, additional education, and job placement be ignored in this discussion of the counselor's role. Such traditional functions of the vocational rehabilitation counselor can be of as much or more value to the substance abusing client as to any other client. These services should be provided in their proper time and place in the rehabilitation process. Similarly, other purchased services of a tangible nature, such as the buying of medical services, uniforms for work, tools, etc., all are important elements in a comprehensive rehabilitation plan. However, great discretion needs to be exercised by the counselor in the timely provision of such services so that they do not appear to be presented as magical solutions to the addiction. Buying a client a new set of mechanic's tools will not keep him/her sober, and sending a client to heating and air conditioning school before he/she has decided to live free of chemicals is premature. First-things-first applies here. The treatment process can assist the rehabilitation counselor in deciding the appropriateness of services as well as when to offer specific services.

If the people in charge of the "treatment process" will communicate with the people in charge of the "rehabilitation process," many costly mistakes can be avoided. Then the role of

the rehabilitation counselor can be effectively defined and implemented.

INTERAGENCY COOPERATION: THE NEED FOR NETWORKING[1]

Rehabilitation counselors long have accepted the need to communicate with and work conjointly with other helping organizations toward the rehabilitation of their mutual clients. Probably with no other disability group is this networking more important than with the substance abuser.

Reasons for Networking

First, the substance abuser often **needs** the services of more than one agency or person to help both him/herself and the family. Secondly, there is a tendency for abusers of chemicals to manipulate in a self-defeating manner persons who are trying to "accommodate" them. Some are expert in playing one agency against another. This tendency should not cause the substance abuser to be seen as a "bad" person but merely as a person who has learned to survive by separating people from one another and then using each person to obtain whatever gratification is desired. This fragmenting of relationships is not unlike the child who learns to manipulate parents who don't communicate with each other very well. The child uses this lack of communication as a way to get what is wanted.

Agencies Commonly Involved with the Substance Abusers

During the treatment process, it can be expected that at least two helping agencies will be involved concurrently with the same substance abusing client: Vocational Rehabilitation and an alcohol/drug treatment program. If the substance abuse treatment program is other than Alcoholics Anonymous or Narcotics Anonymous, then one of those two groups would constitute a likely third organization. In addition, if the substance abuser has a coexisting disability (for example, a hearing problem) then a program specializing in services for the hearing impaired or deaf also would be involved.

In addition to these groups, others that might be involved are the Family Court, The Department of Social Services ("Welfare"), the Probation/Parole Office, Mental Health, or an employer. Traditionally, rehabilitation counselors have assumed, as part of their role, the coordination of services for consumers. In some cases, coordinating has been one of the primary services provided by the rehabilitation counselor. This can be true of the substance abusing client and family, especially when they have only recently begun to consider the existence of the addiction and what to do about it. It can be very confusing to persons with

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[1]The kind of networking described in this section cannot be actualized or attempted without respect for the confidentiality of the client records and the related federal laws. Another section concentrates on the confidentiality law that was written specifically to protect addicted persons. These laws are more restrictive than those rehabilitation personnel use daily. However, it is possible to stay within the law and do the interagency networking that this chapter recommends.

disabilities as to exactly what is available from each agency and how the different services interact with one another. The rehabilitation counselor can help by explaining the purpose of each service, how they will work together, and what is expected from the client. Such coordination can prevent duplication of services and the destructive manipulation of service agencies by the client.

Need for Close Interagency Communication

Some counselors adopt a rather possessive "Lone Ranger" approach in their work with clients, preferring not to "share" their clients with other helping persons. However ill-advised this approach might be with other kinds of disabilities, it is potentially destructive when working with substance abusers.

Even within the structured and closely supervised confines of an addiction treatment center, where communication sessions among staff members are often held every day, most treatment programs do not offer only individual counseling. Most prefer group counseling and the close involvement of other staff. Most addiction treatment programs depend primarily on various kinds of group sessions in their treatment. When individual counseling is used, procedures are established to assure that whatever transpires in the individual session gets communicated to the rest of the treatment staff. This communication is given both in writing and orally, as soon after the individual session concludes as possible.

Any communication from the client is considered confidential among the staff as a group, not between one counselor and the client. Acceptance of one-on-one confidentiality would contribute to the development of a destructive type of dependency between counselor and client. Keeping this information secret would undermine the team approach necessary for effective treatment. In the end, the client would suffer by being denied the combined resources of an informed and coordinated staff.

Close communication among persons working with a substance abuser helps to prevent manipulation by the addicted client. It also enhances the reality orientation of a rehabilitation program. It should make the client more sensitive to his/her place in society, where individual functioning without regard to the feelings, needs and behavior of other people can lead to serious harm. The client will learn that it is not enough to merely "be myself." A person must learn to be him/herself in community with other persons who are trying to be themselves. Substance abuse is largely a human interaction problem, not merely an intrapersonal thing. A substance abuser does not become such by him/herself, in isolation from other people. Therefore he/she is not best treated as a single-person problem or by one counselor or therapist.

NETWORKING AND SUPPORT FOR THE REHABILITATION COUNSELOR

There is another benefit that comes from networking, and the word "supportive" says it well. Substance abusers can be a demanding, dependent, angry, immature, irresponsible, confusing, and depressing group of people with whom to work. This is especially true during the early days of their rehabilitation. Working with persons with coexisting disabilities can be

a very emotionally draining experience. The drain can be a slow, insidious malady that tires and burns out a counselor over a period of months and years. Counselors who work with addicted persons should be sensitive to this drain, for it can affect not only their professional life but also their home life.

Having a supportive network of other professionals with whom to talk on a regular basis about difficult clients can keep counselors in touch with the realities of their own skills and limitations. These professional friends can make the difference between an effective and properly nourished counselor and one who is exhausted, disillusioned, and cynical. Persons who work within treatment centers know very well the need for such support and build it into their daily lives with other staff members. The vocational rehabilitation counselor needs the same kind of sustenance and care.

Although it's difficult to enumerate all the advantages of networking, three very substantial benefits can be stated in closing this section:

1. Networking makes it more likely that the client will receive appropriate and more complete services for him/herself and family;

2. Networking helps greatly to reduce the destructive effects of manipulation by the abuser client by enhancing communication among all agencies that have something to offer the client; and

3. Networking gives the counselor a supportive group of professional friends with whom he/she can share the draining task of working with substance abusers.

KEEPING THE CLIENT INVOLVED

Addiction is a social disease since it usually has its origin among other people and since the abuser affects so many people other than him/herself. Abusers need sensitivity to how other people affect them and how they affect other people. Clients need to know that several other people/agencies are working with them toward rehabilitation. Further, these persons are coordinating and communicating about their rehabilitation. Such understanding can be therapeutic in itself.

It becomes doubly important to communicate openly and often with other professionals if the client with an addiction has another disability. There are times when both disabilities can and must be treated concurrently and other times when the treatment of one should be postponed until concentrated attention is given to the other. The timing and method of delivery of services to a dually impaired client require open dialogue among all involved parties. For example, a deaf substance abuser will need services by specialists for the deaf to prepare him/herself before entering a treatment center designed primarily for those who hear.

Consumers who abuse chemicals need a treatment program before entering a vocational training program. They will need supportive counseling at the same time they are going through training. When all parties involved talk with one another and insist on client involvement in

as many of the discussions as possible, effective coordination is facilitated. In fact, client with coexisting disabilities should actually take the initiative--they should do as much of the planning and contacting as possible.

The Need to Withdraw

It can be helpful in some cases for the rehabilitation counselor to withdraw for a time from direct contact with an addicted client after assisting him/her in getting into treatment. Such withdrawal assists the client in concentrating on treatment as a first need and discourage obsessions about a simple vocational solution.

Two examples of how such withdrawal by the counselor can be beneficial come from an actual case record. A patient in an alcoholism clinic came to the rehabilitation counselor assigned to that clinic and asked the counselor to buy him a set of auto mechanic's tools (a rather expensive purchase). The patient had been fired from several jobs as a mechanic because of his drinking. He reasoned that he could go into business for himself if he had his own tools. He suggested he would be better off in self-employment since (a) he would never fire himself, and (b) he could make more money working for himself than for someone else. The counselor asked him if he had any tools at all, and the client replied, "No, I used to have a complete set but I sold 'em to buy enough booze to go on a big spree several years ago." The counselor concluded that this man needed treatment for substance abuse before any decision should be made regarding vocational goals or the purchase of tools.

Another man came to the same counselor, wanting to be trained as a barber. He was totally convinced that such training would be the answer to all of his problems and was very persuasive when making his request to the counselor. He also thought that he would be better off self-employed (a common theme among substance abusers who have difficulty relating to authority figures such as supervisors). The person was in his second week of treatment, and the counselor told him that it was too early in his treatment program to make any decisions about a vocational objective. Three weeks later, the patient came to the counselor saying that he had changed his mind about wanting to be a barber and could not understand how he ever could have had such a crazy idea.

These two anecdotes point at a common characteristic among addicted persons prior to and during the early days and weeks of treatment: They are addicted not only to their substance(s) of choice but also to solutions to life's problems that are simple, quick, easy, mood-changing, non-relational (not dependent on the establishment of interpersonal relationships), and painless. It can be debated as to whether this companion addiction came into being as a result of the substance abuse or was present in the person's life prior to the onset of the abuse. Suffice it to say that this dynamic is present in a high percentage of cases of addiction, and requests by an abuser client for any specific service should always be evaluated carefully by a counselor. By letting the treatment personnel know about such requests, counselors can benefit from their work with clients and their insights into the reasonableness of client's requests. Addiction treatment at its best helps clients not only to deal with the addiction but also to recognize themselves, their true feelings, interests, and needs. As a result of this insight, clients are able to make more realistic decisions and plans.

VOCATIONAL REHABILITATION AND CHEMICAL ABUSE TREATMENT CENTER COOPERATION

Many agencies have found that they can best accomplish the task of interagency cooperation by assigning one counselor to work as liaison between the rehabilitation office and the treatment center. Sometimes this counselor is placed within the treatment center on a part-time or full-time basis with a caseload of persons with coexisting and substance abuse only disabilities. These specialty counselors are or become knowledgeable about the treatment center program as well as their own agency procedures. As a result they are ideally situated to aid other counselors in their efforts to obtain treatment for their clients. This can be an excellent method of facilitating interagency cooperation.

Rehabilitation counselors in these settings sometimes lose sight of their vocational rehabilitation goals. They can easily become primarily another member of the treatment staff at the treatment center. Experience has shown that it is best to select for such positions counselors whose identity with their rehabilitation agency is well-established.

Regardless of how it is done, interagency cooperation does take time, energy, and sometimes a substantial financial investment by the agencies involved. It requires that persons in different disciplines--working with different policies, procedure, philosophies, funding frameworks, and goals--get to know each other and blend their efforts.

Periodic meetings among the involved parties can be very helpful. Experienced counselors know a significant degree of trust between agency staff must be established before any real cooperation can be expected. Agencies and staff that do not trust or feel comfortable with each other can find all kinds of reasons for not sharing information about clients, attending case conferences, or finding funds with which to provide the needed services. Regular meetings between agency representatives provide an opportunity for "cross-training" regarding service delivery systems, techniques, and agency philosophies.

There is no better way for a rehabilitation counselor to learn about addiction and its treatment than to become involved in an on-going dialogue with a treatment center about an individual who both serve. The counselor and the treatment center become educated about each other and their mutual client. As a result they should work more smoothly together with future clients.

A rehabilitation counselor's trying to work alone with an addicted consumer is like trying to drive a large truck without rear view mirrors. No matter how intelligent or experienced or sensitive the counselor is, more views are needed to provide appropriate services to the client and the family.

CONFIDENTIALITY: THE LAW AND THE WORKING PROCEDURES

The kind of cooperation and communication between vocational rehabilitation and other agencies, encouraged in this chapter, requires the written consent of the client. This section will discuss the law that makes client consent necessary, the details of the form of the consent, and

some issues related to the confidentiality requirements. This is an extremely important section for counselors who wish to protect themselves, their agency, and their clients from illegal disclosures of client information.

Service providers or institutions that receive federal funds and offer services to individuals with chemical dependency are bound by special law requiring strict adherence to confidentiality regulations. The regulations protect the substance abuser from identification as a substance abuser. These regulations are probably unknown to most rehabilitation counselors currently working with alcoholics and drug dependent clients. Further, they are more restrictive than those that are used in the general practice of vocational rehabilitation.

Federal Regulation on Confidentiality

Violation of the confidentiality law can cost a counselor or agency up to $500 for a first offense and up to $5,000 for each subsequent offense. These fines are substantial in themselves. However, they are insignificant compared to the damages that might be alleged by a client whose confidentiality rights have been violated and for which he/she might collect in court. In addition to the monetary cost, there would also be a professional embarrassment to the counselor and agency. Therefore, it is extremely important that all service providers acquaint themselves with the law and comply with it in their daily work with substance abusers.

While the federal statutes discussed here are directed at service providers receiving federal funds, most service professionals and institutions that work with substance abusers comply with these regulations, whether they receive federal money or not. Compliance protects all helping persons from prosecution and enhances the professional image and trust between counselor and client, while protecting the client.

Some judges and many attorneys are not aware that these regulations exist, even though the law was enacted in 1975. Therefore, rehabilitation counselors might find themselves in court, having been subpoenaed to testify in a case involving a substance abuser, only to inform the judge that they can **not** testify on the basis of only the subpoena: They must inform the court that a court order is necessary before the counselor may testify in a case involving a substance abuser. **A counselor is not excused from liability if he/she testifies without the court order, even though the judge (and attorneys) may be unaware of the law.** Obviously, then, to protect themselves and their agency, counselors should know the law and be able to cite it.

A summary of the law is quoted in Figure V-1 and should be required reading material for every counselor and rehabilitation supervisor and administrator. The legal citation for the regulations is 42 C.F.R. (Code of Federal Regulations), Part 2.

Consent for the Release of Confidential Information

The safest way to assure compliance with the law is to have the client sign a "Consent for the Release of Confidential Information." With this form properly completed and in the client's file, the counselor may communicate freely with the person(s) or agencies designated

FEDERAL REGULATIONS ON CONFIDENTIALITY

HUMAN SERVICES

Public Health Service

42 CFR Part 2

Confidentiality of Alcohol and Drug Abuse Patient Records

AGENCY: Alcohol, Drug Abuse, and Mental Health Administration, PHS, HHS.

Action: Final Rule.

SUMMARY: This rule makes editorial and substantive changes in the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations. These changes are an outgrowth of the Department's commitment to make its regulations more understandable and less burdensome. The Final Rule clarifies and shortens the regulations and eases the burden of compliance.

EFFECTIVE DATE: August 10, 1987.

FOR FURTHER INFORMATION CONTACT: Judith T. Galloway (301) 443-3200.

SUPPLEMENTARY INFORMATION: The "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations, 42 CFR Part 2, implement two Federal statutory provisions applicable to alcohol abuse patient records (42 U.S.C. 290dd-3) and drug abuse patient records (42 U.S.C. 290ee-3).

The regulations were originally promulgated in 1975 (40 FR27802). In 1980 the Department invited public comment on 15 substantive issues arising out of its experience interpreting and implementing the regulations (45 FR 53). More than 450 public responses to that invitation were received and taken into consideration in the preparation of a 1983 Notice of Proposed Rulemaking (48 FR 38758). Approximately 150 comments were received in response to the Notice of Proposed Rulemaking and were taken into consideration in the preparation of this final Rule.

The proposed rule made both editorial and substantive changes in the regulations and shortened them by half, changes, with some significant substantive modifications and relatively few editorial and clarifying alterations.

Synopsis of Substantive Provisions

The Confidentiality of Alcohol and Drug Abuse Patient Record regulations (42 CFR Part 2) cover any program that is specialized to the extent that it holds itself out as providing and provides alcohol or drug abuse diagnosis, treatment, or referral for treatment and which is federally assisted, directly or indirectly (§ 2.12(a) and (b).

The regulations prohibit disclosure or use of patient records ("records" meaning any information whether recorded or not) unless permitted by the regulations (§ 2.13). They do not prohibit giving a patient access to his or her own records (§ 2.23). However, the regulations alone do not compel disclosure in any case (§ 2.3(b).

The prohibition on disclosure applies to information obtained by the program which would identify a patient as an alcohol or drug abuser (§ 2.12(a)(1). The restriction on use of information to investigate or to bring criminal charges against a patient applies to any alcohol or drug abuse information obtained by the program (§ 2.12(a)(2)).

Any disclosure permitted under the regulations must be limited to that information which is necessary to carry out the purpose of the disclosure (§ 2.13).

The regulations permit disclosure of information if the patient consents in writing in accordance with §2.31. Any information disclosed with the patient's consent must be accompanied by a statement which prohibits further disclosure unless the consent expressly permits further disclosures or the redisclosure is otherwise permitted by the regulations (§ 2.32). Special rules govern disclosures with the patient's consent for the purpose of preventing multiple enrollments (§ 2.34) and for criminal justice referrals (§ 2.35).

The regulations permit disclosure without patient consent if the disclosure is to medical personnel to meet any individual's bona fide medical emergency (§ 2.51) or to qualified personnel for research (§ 2.52), audit, or program evaluation (§ 2.53). Qualified personnel may not include patient identifying information in any report or otherwise disclose patient identities except back to the program which was the source of the information (§§ 2.52(b) and 2.53(d).

The regulations permit disclosure pursuant to a

court order after the court has made a finding that "good cause" exists. A court order may authorize disclosure for noncriminal purposes (§ 2.64); for the purpose of investigating or prosecuting a patient if the crime involved is extremely serious (§ 2.65); for the purpose of investigating or prosecuting a program or a person holding the records (§ 2.66); and for the purpose of placing an undercover agent or informant to criminally investigate employees or agents of the program (§ 2.67).

A court order may not authorize disclosure of confidential communications unless disclosure is necessary to protect against an existing threat to life or serious bodily injury of another person; to investigate or prosecute an extremely serious crime; or if the patient brings the matter up in any legal proceedings (§ 2.63).

A court order may not authorize qualified personnel who received information without patient consent for the purpose of conducting research, audit, or program evaluation, to disclose that information or to use it to conduct any criminal investigation or prosecution of a patient (§ 2.62). Information obtained under a court order to investigate or prosecute a program or other person holding the records or to place an undercover agent or informant may not be used to conduct any investigation or prosecution of a patient or as the basis for a court order to criminally investigate or prosecute a patient (§ 2.66(d)(2) and § 2.67(e)).

These regulations do not apply to the Veteran's Administration, to exchanges within the Armed Forces or between the Armed Forces and the Veterans' Administration; to the reporting under State law of incidents of suspected child abuse and neglect to appropriate State or local authorities; to communications within a program or between a program and an entity having direct administrative control over the program; to communications between a program and a qualified service organization; and to disclosures to law enforcement officers concerning a patient's commission of (or threat to commit) a crime at the program or against personnel of the program (§ 2.12(c).

If a person is not now and never has been a patient, there is no patient record and the regulations do not apply (§ 2.13(c)(2)).

Any answer to a request for a disclosure of patient records which is not permitted must not affirmatively reveal that an identified individual has been or is an alcohol or drug patient. One way to make such an answer is to give a copy of the confidentially regulations to the person who asked for the information along with general advice that the regulations restrict the disclosure of alcohol or drug abuse patient records and without identifying any person as an alcohol or drug abuse patient (§ 2.13(c)).

Each patient must be told about these confidentiality provisions and furnished a summary in writing (§ 2.22).

There is a criminal penalty for violating the regulations; not more than $500 for a first offense and not more than $5,000 for each subsequent offense (§ 2.4).

Figure V-1

within the restrictions specified on the form. A sample of the consent form is found in Figure V-2 and may be copied and used by any person or agency. Clearly, this form is considerably more specific in several areas than the more generally worded form used by most counselors, attorneys, and insurance companies.

Counselors might receive a consent form from another agency, requesting information about their clients. If this form contains all the required elements in a sequence different from the form in Figure V-2, it is acceptable. While the elements can be rearranged and worded differently to some extent, the specificity of all elements must be present. Also, the counselor should make sure that the client understands what he/she is signing, what information is to be sent, and for what purpose it will be used.

When the requested client information is sent, with client consent, a cover sheet should be attached that warns the receiving office about further sharing of that information with anyone not specifically named on the consent form as a recipient. This warning is contained in Figure V-3. The use of this warning further protects the counselor sending the information and alerts the receiving office to the confidentiality regulations.

The regulations might seem to pertain mainly to treatment center records. However, rehabilitation counselors are not exempted from the law even though they may not consider themselves a "treatment" person. A counselor who accepts persons as clients who have a diagnosis of alcohol or drug dependency must comply with the law as must a psychiatrist in a treatment institution.

Earlier in this chapter, vocational rehabilitation counselors were encouraged to work closely with other treatment persons and agencies in providing services to substance abusing clients. This latter part of the chapter is not intended to discourage such interagency effort. Communication among agencies regarding substance abusing persons is necessary to ensure good service and can be done comfortably with a properly completed and signed consent form.

It should be noted that active clients, applicants for services, and former clients and applicants (closed cases) are covered by the law. If the record indicates the person with a disability has a substance abuse problem then all agency communication is covered by the federal law.

Legal Ways to Share Information

According to 42 CFR, Part 2, obtaining a signed consent form is only one way that makes such sharing of confidential information permissible. Therefore, a list explaining other ways that confidential information about a substance abusing client can be shared legally with others is presented. If the answer "yes" can be given to any of the following questions, the situation permits communication of confidential material (interpolated from 42 CFR, Part 2):

1. Has the client executed a proper consent form for the proposed communication (as specified on the consent form)?

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize
(name of client or participant)

_____ to disclose to
(name of program making the disclosure)

_____
(person or organization to whom disclosure is to be made)

the following information _____
(nature of information)

_____

Purpose of the disclosure is _____

_____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. also understand that I may revoke this consent at any time except to extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below.

Specifications of the date, event, or condition upon which this consent expires _____

_____

Executed this _____ day of _____, 19 _____

_____
Client or participant signature

_____
Witness

_____
Guardian signature
Relationship: _____

Date revoked: _____

_____
Client signature

_____
Witness

Figure V-2

COVER SHEET FOR CONFIDENTIAL INFORMATION

****

PROHIBITION ON REDISCLOSURE
OF INFORMATION CONCERNING CLIENT
IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records whose confidentiality is protected by Federal 12 law. Federal regulation (42 Code of Federal Regulations, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

****

Figure V-3

2. Is the proposed communication to be made to other staff within the program or to an entity with administrative control over the program (vocational rehabilitation office or network of agency offices, for example)?

3. Can the proposed communication be made without revealing that the person the disclosure concerns is or was a substance abuser?

4. Is the proposed communication related to a medical emergency? (If it is necessary to reveal a client's addiction in order to obtain appropriate emergency care, such giving of information is permitted.)

5. Is the proposed communication authorized by a valid court order? (See the summary of the law given in Figure V-1 for situations that do not support or justify a court order.)

6. Does the proposed communication concern a crime or a threatened crime on the premises of the program or against program personnel? (Actually, any threat against any person that is believed to be a serious threat should be reported to law enforcement personnel. The reporting person can still use discretion as to whether or not to reveal that the threatening person is a substance abuser.)

7. Is the proposed communication for purposes of research or part of an audit or examination of a program's activities? (Such studies usually do not require individual identification of any person, certainly not outside the office where the records are kept.)

8. Does the proposed communication involve the reporting of child abuse or neglect? (Later revision of the law makes it possible for persons to comply with state laws that require reporting of child abuse or neglect. A substance abuser may, therefore, be reported for such abuse or neglect.)

9. Will the proposed communication be made pursuant to a "Qualified Service Organization Agreement"? (A "Service Organization" is a person, business, or agency that provides specialized services to a treatment or counseling program or office, such as preparation of medications, data processing, laboratory analyses, or professional consultation in the areas of law, medicine or accounting. Such persons, who are not a part of the daily operation of the treatment or counseling office, might need to have access to protected records or to persons in treatment. By signing a "Qualified Service Organization Agreement," (see Figure V-4), such service providers may access information not otherwise available to them. The wording of the agreement binds them as much as the professional counselor to protect the confidentiality of the addicted client.)

Professional Responsibility Regarding Releasing Information

It should be emphasized that a signed consent by the client does not order a counselor to share confidential information but only gives permission to do so. There will be situations in which the counselor may feel it is against the client's best interests to share information even though the client has signed the consent form. Also, the counselor can decide how much of the permitted information is appropriate for sharing. For example, the counselor might decide to share most of the progress notes about a client, but not all. The counselor should always make sure that the client understands the nature and general content of the information to be released so that the client might give informed consent. In the decision to share information, counselor judgment must come into play, as in many other situations facing the counselor.

It is the identification of the client as a substance abuser that is most important to protect. The best way for the counselor to protect him/herself from liability is to have a signed consent form, properly completed, in the file. The proper completion of this form requires the stating of an expiration date for the consent, and this should be kept in mind if information is to be shared over a considerable period of time. It might be necessary to have the client sign a new form at some point if time runs out on the original consent.

When communicating with employers, the counselor should not feel under any obligation to share any confidential information, even with a signed consent form. Absolutely nothing should be shared with an employer without a signed consent. This restriction puts the placement counselors in a severe dilemma. On the one hand they must observe confidentiality. On the other hand, they may feel an obligation to be honest with the employer.

In many confidentiality situations with employers, one of the major temptations facing the counselor is a relationship of established informality. That is, the counselor may have known the employer for years; they might play golf together; they might be next door neighbors or even relatives. Such a trusted relationship might seem to make it permissible for the counselor to share certain confidential information with the employer after telling them the

QUALIFIED SERVICE ORGANIZATION AGREEMENT

XYZ Service Center ("the Center") and the _____

_____

(Name of the Program)

(the "Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide _____

(Nature of services to be provided)

_____

Furthermore, the Center:

1. Acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the patients in the Program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; and

2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 C.F.R. Part 2.

Executed this _____ day of _____ 19_____.

_____ _____

President
XYZ Service Center
(address)

Program Director

_____

Figure V-4

employer information is confidential. However, even in this situation the counselor must not do so if the law is to be respected.

In most cases, employers will not push for information that is protected. They understand such regulations and, indeed, must comply with other confidentiality laws themselves at the work place. Certainly, the employer has no need, no right, to know the details of what a client is doing in therapy. In most cases, the client does not mind the employer knowing that he/she is involved in regular therapy sessions and is making progress and will give consent for

this kind of information to be shared, if requested.

The consent form calls for the listing of specific information that is to be released, so that only what the client releases is shared. Of course, clients may tell anyone anything they wish. A client may choose to confide whatever he/she wants to an employer.

With regard to child abuse/neglect reporting, most states now have laws that require anyone knowing of such a situation to report it to the authorities. The federal law regarding confidentiality of alcohol/drug records was revised specifically to permit such reporting. Counselors are advised to find out what their state's law requires on this matter and be guided by the law.

It should be remembered that a court order is necessary if a counselor is to testify in court; a subpoena alone is not sufficient. The counselor who receives such a subpoena should notify the court as soon as the subpoena is received that federal law requires a court order for such testimony. Of course, a signed consent form also frees a counselor to testify if it is worded to specifically allow testimony. However, it is unlikely that a client in such a case is going to voluntarily give such consent unless he/she feels that the counselor's testimony will support the client's case.

At this point, the reader is referred to the excellent book published in 1988 by the Legal Action Center of the City of New York, entitled Confidentiality: A Guide to the New Federal Regulations. This book has been of much value in the writing of this chapter and should be in the hands of every person working in the field of alcohol and drug abuse counseling and treatment. It can be obtained directly from the Legal Action Center, 153 Waverly Place, New York, NY 10014.

Chapter VI

MODEL PROGRAMS AND COMPONENTS

This chapter will discuss the following issues:

- Components of an integrated model substance abuse program for persons with a coexisting disability.
- Special considerations for persons with physical or mental disabilities.
- Staff training issues across professions.

Even though many alcohol and drug programs are 100% architecturally accessible to people with disabilities, many of these same programs are not attitudinally accessible to the real needs of these potential recipients of service. For example, there are programs that meet all of the architectural requirements of accessibility, but the staff of these same programs are not prepared to work with people who have communication, developmental, mental, physical, and/or sensory disabilities. The primary problem is the lack of training of alcohol and drug treatment service providers regarding the accommodation of persons with coexisting physical or mental disabilities.

Of course, the same holds true for people who are expert on the needs of people with disabilities. That is, their programs are fully accessible to meet the needs of people with mobility limitations but, their personnel are untrained in how to successfully provide rehabilitation services for consumers with alcohol or other drug addiction as a coexisting disability.

By treating someone with a physical or mental disability who also has an alcohol or other drug problem, the following are accomplished:

1. Cost effectiveness.
2. Humanistic services.
3. Benefits to the individual, the family, and society.

When a system is not sensitive to the needs of people with coexisting disabilities it:

1. Unnecessarily institutionalizes people with disabilities.
2. Does not allow the persons to complete their physical or mental rehabilitation. As a result, a burden is placed on the economy of the country because the disability

of addiction was not alleviated.

3. Prevents individuals with newly acquired life-limiting disabilities from going through the grieving process as they are anesthetizing themselves with alcohol and/or other drugs.

4. Causes persons with disabilities to be shut in at home, to become homeless, or suffers needless loss of quality of life.

5. Allows medical and legal bills to escalate as a result of not treating the addictive behavior.

6. Prevents the provision of the necessary services which also affects the rehabilitation system. Rehabilitation, alcohol and drug counselors, and other professionals who work in the field do not have adequate resources and/or skills to deal with this problem in a comprehensive manner.

Rehabilitation professionals have a responsibility to address alcohol and other drug dependency issues with their clients. The failure to do so may prevent the person's successful rehabilitation and adjustment to the disability, and it may lead to increased medical complications and/or interfere with development toward independent living. For this reason, persons with disabilities require access to substance abuse treatment programs which are commensurate with their special needs. These programs will require a number of adaptations or additions to existing services. The treatment program should be flexible in structure in order to provide appropriate treatment for a variety of clients with differing abilities. This degree of flexibility allows clients to grow in their understanding and development of their self in regard to their disability and substance abuse.

An important precept is that individuals with a disability participating in a substance abuse treatment program are there because of the substance abuse and not because of other disabilities. They should be treated no differently than other group members, except for reasonable accommodations for the handicaps caused by their physical or mental disability.

COMPONENTS OF A SPECIALIZED SUBSTANCE ABUSE TREATMENT PROGRAM

The following is a list of components that could be used to improve or develop a more accessible substance abuse treatment program for individuals with disabilities. It is recognized that not all treatment programs and facilities contain all the components listed below. However, there are specialized treatment programs that have incorporated many of the elements listed.

- Initial Assessment Process
- Integrated Treatment Program
- Self-Help Support Groups
- Family and Other Community Support Systems
- Staff Trained in Accessibility Needs

- Chemical Dependency Evaluation Process
- Adaptive Recreation
- Counseling--Individual, Group, Family, and Peer
- Aftercare
- Other Special Treatment Considerations for Persons with Physical or Mental Disabilities
- Disability Awareness Training (this will be discussed in the last section of this chapter).

The overall goal of an effective substance abuse treatment program for persons with disabilities should, in most cases, be total abstinence rather than controlled use. This is especially true for traumatic brain injury, other neurological impairments, severe and persistent mental illness, cognitive impairments, and central nervous system disabilities.

Initial Assessment Process

An assessment of the needed treatment services should be completed for the person with a disability prior to admission to a substance abuse treatment center. An additional assessment is required by the treatment center as to its meeting the physical, cognitive, and medical needs of an applicant for substance abuse services who happens to have a physical or mental disability. Certain reasonable accommodations are necessary from the treatment center so these individuals can be served. In this case reasonable accommodations can be defined as making existing facilities readily accessible, such as ramping stairways, wide doors, bathrooms that are wheelchair accessible, etc.; acquiring modified or modifying equipment or devices; adjusting or modifying examinations, training materials, or policies to accommodate the disability; modifying or restructuring treatment; providing readers or interpreters; and/or providing personal care attendants, brailling materials, and/or writer services. These needs must be met before the substance abuse issue can be adequately and properly addressed.

Integrated Treatment Program

An integrated treatment program, one which includes nondisabled as well as persons with disabilities, is probably the first and most important component of a disability oriented substance abuse treatment program. The rationale for integration is that part of the client's recovery process is becoming a functional member in the community. An integrated program teaches a person with a disability how to function in a mainstreamed environment. Persons with disabilities are expected to participate with persons without disabilities in most scheduled program activities. In many treatment programs adaptations must be made to accommodate individual needs to assure full participation. An example is the provision of interpreters for hearing impaired clients at AA meetings.

In an integrated program, the responsibilities are the same for persons with disabilities as for persons without disabilities. Persons with disabilities may do things a little differently, but the responsibilities are the same. For example, if a person with a spinal cord injury is in a substance abuse treatment program, the question that usually comes up is "What time do you start the treatment program?" The program needs to start at whatever time it would have started if there was not a person with a spinal cord injury involved. Most people would respond by

saying, "Can you expect a person with a spinal cord injury to be ready by that time?" The response is "Yes, we do." This may mean that the person with a spinal cord injury may have to start getting ready two to three hours earlier than the other members of the program. This may seem unfair for that person; but, unfortunately for the rest of that person's life, if he/she is going to go to work, school, or fishing on the weekend, it may take them two to three hours to get ready when for most people it takes only 30 minutes.

All persons are expected to complete assignments in a treatment program no matter what may be their disability. If a person has a spinal cord injury and is unable to write, then it becomes that person's responsibility to figure out with the facilities staff how he/she is going to get the task completed. The person may dictate material to a fellow patient or find a staff person who is willing to assist; or he/she may need to get a tape recorder, learn to use a typewriter, etc. The important feature here is that there are set expectations, and it becomes the person's responsibility to get the tasks completed.

Self-Help Support Groups

The authors recognize that all self-help groups do not follow the twelve-step program of Alcoholics Anonymous. However, the twelve-step program is the most widely used philosophy behind the majority of self-help groups.

The Alcoholics Anonymous/Narcotics Anonymous (AA/NA) support groups use a treatment model which represents an approach that has a long history of success in the field of substance abuse. This model emphasizes an individual's lack of control over his/her dependency and abuse, encourages peer support, and emphasizes spiritual needs. AA/NA support groups are widely available throughout the country. They can provide a source of community based aftercare services. The earlier clients become integrated with this support program, the easier it will be for them to continue in similar groups within their home community. In the initial stage of the treatment program, counselors are encouraged when possible to accompany their clients to these meetings and assist clients in participating, learning, and integrating the relevant material from meetings into their treatment.

One of the difficulties of the AA/NA model is that it depends, to a large degree, on the use of insight and verbal discourse throughout the treatment program. This method may need modification for many persons with brain injuries or other cognitive dysfunctions which impair the capacity for insight into the behavioral factors related to their abuse and dependency. Memory impairment, which is frequently seen in individuals with brain injury, greatly limits the ability to acquire and retain an ongoing awareness of feelings, behavior, or insight that may have developed. In addition, it may be difficult in the group treatment setting for the person with brain injury to inhibit impulsivity, attend selectively, process auditorial, and respond verbally, given the frequency and diversity of cognitive deficits. Similarly, other clients with cognitive deficits and central nervous system damage may be unable to use the AA/NA model effectively (Blackerby & Baumgarten, 1990). Other groups that may be at a disadvantage are the deaf and hard of hearing. Individuals with these disabilities are disadvantaged by the fast movement of the conversation from one group member to another, even when interpreters are used. In large cities, it may be feasible to start specialized self-help groups for persons with these disabilities who find integration a severe problem.

Family and Other Community Support Systems

One of the truisms about alcohol and drug abuse is that it is a "family disease." This statement is made for two reasons: First, persons with alcohol and drug addictions commonly come from families with a history of chemical abuse. While this may or may not provide support for a genetic predisposition towards chemical abuse, it almost certainly means that the person has learned inappropriate, if not destructive, ways to deal with problems and interpersonal relationships. Second, when a person abuses alcohol and/or drugs, he/she affects the lives of all of those around him/her. The role of each family member often changes in response to the substance abuse of one person. While this typically falls heaviest on spouse and children, it also affects siblings, parents, and other relatives.

If there is an intervention process, family members can be critical participants of an intervention group. Because these are the persons who commonly **know the addicted person the best** and who frequently have suffered the most from the addiction, they are in a perfect position to confront the person's abuse.

This family disease concept means that the entire family needs help either before the addicted person quits or immediately after the client stops the use of substances. There are a variety of support services to help the family. The first are self-help groups that are based on AA/NA:

1. **Al-Anon Family Groups**. This self-help group is a "Fellowship of men, women, and children whose lives have been affected by the compulsive drinking of a family member or friend" (Madara & Meese, 1990, p. 28.). The largest family support group, this program uses the AA twelve steps and often shares the same facilities with AA/NA. For information on starting a meeting call: (212)302-7240. For meeting information call: (800) 344-2666. Write: Al-Anon Family Group, P.O. Box 862, Midtown Station, New York, NY 10018-0862.

2. **Alateen**. Another AA sponsored and inspired group, as its name suggests, it is designed specifically for teenagers who are affected by someone else's substance abuse. Call: (212)302-7240 or (800) 344-2666. Write: Alateen, P.O. Box 862 Midtown Station, New York, NY 10018-0862.

3. **Adult Children of Alcoholics**. "A 12-Step, 12-Tradition program of discovery and recovery for adults who realize that the characteristics which allowed them to survive as children in an alcoholic dysfunctional home now prevent them from fully experiencing life" (Madara & Meese, 1990, p. 28). Write: Adult Children of Alcoholics, P.O. Box 3216, Torrance, CA 90510.

In addition to these self-help groups, there are other community resources that can assist the professional in dealing with alcoholism and drug abuse. Many of these are community agencies:

1. **In-patient and Out-patient Treatment Programs**. Most of these programs offer family counseling and family services. Some have special programs for family members.

2. **Social Service Agencies.** Many private social service agencies deal with the family of the addicted person.

3. **Women's Programs and Shelters.** These organizations can provide temporary shelter during crisis times.

4. **County/City Social Services.** Public human services departments can offer programs and information.

Staff Trained in Accessibility Needs

The best method of acquiring accessibility knowledge is cross-training with rehabilitation professionals. Staff should also ask clients what accommodations are needed and solicit suggestions on how that might be accomplished.

Chemical Dependency Evaluation Process

An evaluation team, one that knows about disabilities and chemical abuse/dependency, should conduct a substance abuse evaluation on all persons with coexisting disabilities who are requesting services. This team should consist of a Certified Chemical Dependency Practitioner (CCDP) and a person who has been educated in the field of rehabilitation and/or has experience in the area of disability. If such an evaluation team is not available, it is recommended that individuals be employed who are interested in learning about rehabilitation and substance abuse in general and about the client's disability specifically. By having staff trained in both rehabilitation and substance abuse, many myths about substance abuse and persons with disabilities may be avoided.

Adaptive Recreation

The importance of adaptive recreation cannot be overlooked. Consequently, recovering people need to participate in as many different recreational activities as possible. One of the greatest difficulties most substance abusers have is occupying their time with meaningful recreational activities. While using and abusing, much of their time was spent procuring and using drugs or alcohol. Now that they are no longer using, they discover a tremendous amount of free time. The concept of leisure time activities is somewhat foreign to many chemically dependent persons, especially a person with a disability. There is also a tremendous amount of guilt associated with leisure activities for a recovering alcohol or drug user.

Most recreational activities are designed for people without disabilities. Even the spectator aspect of many sporting activities is quite limiting if, for example, people with hearing impairments or wheelchair users are considered. Ideally, adapted and appropriate recreational activities are available for involvement as a participant or spectator. A recreational therapist who has a background in working with people with disabilities can be of great assistance in modifying and adapting recreational activities as well as educating clients on utilizing leisure time.

Counseling

One of the cornerstones in successful substance abuse treatment is the counseling process. This process involves many different components: individual, group, family, and peer counseling. It is important to maintain a balance among reinforcement, support, and confrontation of inappropriate attitudes and behaviors on the part of the client.

Individual counseling. Some clients find the counseling process more helpful if the counselor is disabled and a recovering substance abuser. Traditional programs may provide someone who can discuss what the disabled person may be feeling, but it is usually on an intellectual level rather than a empathic level. There is a powerful advantage of discussing problems with another person who has a disability on the same emotional level and may have experienced similar feelings, thoughts, hope, aspirations, and dreams. This can provide some additional support due to the fact that the counselor "has been there" also.

Group counseling. An important element of any substance abuse treatment program is the weekly support group. This group should be led by professionals who are experienced in counseling those with alcohol and other drug dependencies as well as disability related issues. Schaschl and Straw, (1989) in an unpublished study, found that among 69 patients, followed over a one-year period of time, there was a direct correlation between those persons who stay active in the disability support group and those who report complete abstinence from alcohol and unprescribed drugs for a minimum of six months after admission.

The group discussions are centered around disability issues that are not included in regular treatment group meetings such as adjustment to the disability issues, sexuality, employment issues, etc. Group members are encouraged to relate personal concerns. The peer support and diverse experience of the group members provides fertile ground for personal growth and creative thinking as members begin to integrate into an able-bodied society.

Family counseling. Family counseling will allow the family to sort out the interaction between the client's chemical use, his/her disability, and how the two areas feed each other. Counseling can help the family start to forgive themselves for the client's problems. Guilt is especially likely for families who have children who are congenitally disabled and now feel somehow it is their fault that the child is chemically dependent. Counseling can help them understand, express, and deal with anger, guilt, and other feelings that may have been suppressed because of the disability issues.

Peer counseling. Peer support is important for anyone going through substance abuse treatment. This is as true for chemical dependency programs for individuals with disabilities as it is for men's programs, women's programs, Hispanic programs, child programs, or death and dying programs.

Peer support groups are useful for those people who have a disability and are choosing to be substance free. This group is designed to be a place that people can come together to exchange ideas, support, and inspire one another. It is also a process which offers a tremendous amount of trust in one's contemporaries.

There clearly is some value in the experiential kinds of learning. The ability to support someone in a very difficult time because the peer may have gone through a similar or same experience is helpful. Being in treatment and not having someone to talk to about issues related to the disability may mean the client could say, "You don't understand because you don't have a disability." This usually is not done because the person wants the counselor to understand, but because he/she may want to get the other person to stop demanding they meet expectations. Some people with disabilities have used this method at some time in their lives to relieve the pressure to conform. This technique does not work as well with a peer who is also disabled.

The grieving process that people normally go through when adjusting to a disability may have been blunted or blocked due to their substance use. The process of adjusting to and coping with the feelings of what has happened to him/her may be what is coming to the surface for the first time when the client stops using. It is not until the chemicals have dissipated that the person may begin the process of adjusting. For example, people may be coming to the group in the denial stage; "I don't need to be in this group with all these disabled people."

Some people may enter the process when they are in an anger stage--angry at God, society, their parents, those who do not have a disability, or the world at large. Some people enter when in a stage of grieving where they are very sad and depressed and feeling helpless and hopeless. These are the various types of issues that most group participants are working through.

The intent of groups is not designed to be a social or a how-to group, but rather to focus on feelings, not fixes or solutions. Dealing with and addressing feelings is the major purpose of these groups because that is what substance abuse has dismissed or covered up. After all, becoming in touch with one's feelings is the initial step of the adjustment and acceptance process. The facilitators try to maintain the focus on feelings and process oriented material. The group is primarily responsible for what happens. All members are asked to take a serious look at where they are and where they want to be. The pressure to change their behavior and attitudes is coming from their peers. The group spends most of the time processing the feelings expressed during group sessions.

Aftercare

Finding an appropriate continuing care program after a person is discharged from an inpatient treatment program and trying to make appropriate community connections is extremely difficult. This is where most substance abuse rehabilitation processes fall apart. What happens to the person after he/she leaves the treatment program? Where will he/she go for continuation of treatment? How will he/she get there? Who will work with him/her on individual needs? Are there accessible treatment programs within the community, and if not, what then? These are important questions to be considered prior to discharge. It is suggested that these concerns be addressed at the beginning of the treatment program rather than the end.

The process of discharge planning involves many components: the exploration of support resources within the clients' home community, the development of an appropriate placement after discharge, the development of a support system (NA/AA sponsors, family, friends, and vocational rehabilitation counselor), and the education of this support system.

Halfway houses for people with disabilities are few and far between, especially if there is a mobility impairment and architectural accessibility is needed. When suitable facilities are found, funding and licensure usually become issues. Another problem that often seems insurmountable is when the client requires personal care. Many halfway houses that are licensed are unable to accept those who are unable to care for themselves. Many persons with coexisting disabilities would be referred for halfway house service if they didn't have the other disability, but because of the disability, they are not referred. This is when many clients lose their treatment momentum. A client may do well in inpatient treatment but then return to an unhealthy environment. They may return to or secure housing at segregated or congregated living facilities. This type of environment has the tendency to promote more isolation, dependency, and enabling conditions.

Unfortunately, this is where some clients with coexisting disabilities end up after completing an inpatient treatment program. This does not provide much hope for the recovery process. A nondisabled person who completed treatment may more easily find a place to stay for a short time until a more suitable permanent place can be found. Persons who have a mobility impairment who need accessibility and/or attendant care have much more difficulty. Where are they going to find an attendant who is not using? Where are they going to find accessible housing? Placement after treatment continues to be the most difficult part of recovery for many people with disabilities. When people with disabilities are discharged into the community with no assistance in making connections with other recovering people with disabilities, it subverts any progress that has been made. There is an incredible need for more integrated groups to be started in every community.

Careful consideration must be given to the client's ability and motivation to attend aftercare treatment programs. What extent of external structure is required by the client to maintain sobriety and remain chemically free must also be addressed. Does the client have the ability to make independent support contacts, and what other support is needed to ensure success? Many clients need to develop and follow an action plan when the need to return to substance abusing behaviors occurs. This need (relapse) will occur with most, if not all, clients at some time following discharge. The action plan has been referred to as the "Disaster Plan" and usually involves the use of coping and relaxation skills learned and practiced in the program, self-instructions, and a list of individuals who can be called on for support or assistance (such as an AA or NA sponsor, family, a friend, or a counselor). The clients then present their plans to their treatment team, other clients, and family to obtain reinforcement and support.

The continuation of AA or NA is also an important aspect of aftercare treatment. The client and family may need assistance in determining the location, dates, and times of meetings in their community. Further assistance may be needed in finding suitable sponsors and arranging for adequate transportation. Contacts with vocational rehabilitation counselors and community social groups, including local disability related association support groups, may also need to be developed by or for the client.

Special Treatment Considerations for Disability Subgroups

Persons with disabilities may have physical, mental, cognitive, and emotional limitations. These limitations become a concern when they impinge upon the person's security, safety,

comfort, and most importantly, the ability to actively participate in a treatment program.

The following recommendations are taken from Beyond Ramps: A Guide for Making Alcohol and Drug Programs Accessible (Cherry, 1988).

Mobility Impairments

Individuals with mobility impairments may be more or less accepting of their disabilities and/or willing to discuss them. The general principle to keep in mind is that an individual is participating in a program because of a problem with alcohol or other drugs, not because of the physical condition.

It is important that organizations of or for people with mobility impairments be informed of facilities that are accessible. An important guiding principle is that individuals with mobility impairments are themselves the best experts on how to manage their disabilities. Staff should not assume they know what physical aids an individual with a mobility impairment is accustomed to using. Rather, they should encourage that individual to communicate needs or suggestions during the program.

Maximizing participation. While many facilities claim accessibility since they offer a ramp to an entrance or elevators to upper floors, many other aspects of a building must be considered for true accessibility to a program.

Accompany a person with mobility impairments on a tour of the facility as early as possible. Ask them to indicate any structural features which may be problematic and any modifications that could be made.

- Is there room for a person in a wheelchair to close and lock the bathroom door? Can he/she turn on and regulate faucets? Reach towels? Use tub or shower?

- Are hallways and passageways free of clutter, plants, and obstacles? Is there enough space for a wheelchair to turn around? For two wheelchairs to pass in a hallway?

- Are utensils usable by someone with limited mobility or dexterity? Is the dining table itself accessible, or can some accommodation be made?

- Do lounging areas offer places to "park" a wheelchair that foster socializing but are not in the flow of traffic?

- Are doorways wide enough to accommodate a wheelchair? Can they be opened and closed easily by someone with limited mobility or dexterity? Are locks easily unlocked? Are exits clearly marked?

The initial orientation tour to the program provides an ideal opportunity to acquaint each individual with emergency procedures, equipment such as fire extinguisher, and exit routes.

Deaf and Hard of Hearing

It is important to differentiate between a person who is hard of hearing and a person who is deaf. When talking with a person with hearing impairment, if there is any doubt whether an individual is understanding the dialogue, ask a pertinent question.

If the individual is deaf, write simple sentences to acknowledge that you understand s(he) is deaf and that you are arranging interpreting assistance as soon as possible. Never sit with your back to a window, lamps, or other light sources when talking with a hearing impaired person. Lip or speech reading is very difficult when looking into bright lights.

Outreach to deaf. The following are some considerations for working with persons who are deaf.

- Advertisements on television should be captioned and/or in American Sign Language (ASL). Printed materials that are pictorial and use simple English explanations are helpful.

- When setting up appointments for deaf individuals, be sure to arrange for interpreting services.

- When referring a deaf individual to other agencies, be sure to inform those agencies that an interpreter is necessary.

- Use paper and pencil if they are offered by the person with a hearing impairment or if communication is questionable. Again, use clear and simple language.

- Information about services might be placed in organizational newsletters (i.e., state organizations for the deaf or chapters of self help groups for persons who are hard of hearing).

Maximizing participation. While a competent ASL interpreter either on staff or contracted on an as-needed basis is essential to providing services to people who are deaf, there are other aspects to consider as well:

- Be sure that the hard of hearing are seated in groups or lectures in locations where they can hear and see most of what is happening.

- Since many deaf people do not have the English language skills of hearing people, contract forms and printed materials should be written to their ability or an interpreter should be asked to assist with the materials.

- Do not assume that a hearing-impaired individual understands what is transpiring; people do not like to appear ignorant and may smile or give other cues they understand when they are actually missing many details.

- Go over your program plan, the layout of your facility, emergency plans, etc.,

when an interpreter is present. Much of what we learn about facilities and programs is overheard and through word of mouth. People with hearing impairments do not get that education.

- Be willing to stop, speak slowly, or write notes. A sense of participation and belonging is important to all program participants.

Sign language interpreters. A key to providing effective services to clients who are deaf is to understand them as belonging to a distinct cultural group. Sign language interpreters are as essential to working with clients who are deaf as bilingual staff or interpreters are for those who speak little or no English. The following pointers are offered for agencies unaccustomed to working with interpreters.

- Obtain interpreters based on the individuals' needs. Sign Language skill, education levels, and English skills vary, the same as with hearing people.

- Use interpreters who are certified. Not all people who use American Sign Language are qualified for the sometimes strenuous tasks of interpreting or are familiar with the interpreters' code of ethics.

- Make time to first meet with the interpreter so that you can maximize that person's skill. He/she can tell you how best to set up interviews, lecture rooms, etc.

- Always talk to the person who is deaf--not to the interpreter.

- Use the minimum number of interpreters possible. The same interpreter for the duration of a client's stay in your program is most preferable. However, for all-day programs or classes, two interpreters that can trade off are necessary.

Special needs and programs. There are several adaptive aids that should be available when an inpatient program is serving persons who are deaf or hard of hearing. Among them are the following:

- Visual alarm systems which allow persons who are deaf to receive warnings (the same as bell systems for persons who are hearing).

- Various systems for telephone communication are available, but the TDD (Telecommunication Devices for the Deaf) system is becoming the standard.

- Telephones with amplifiers for persons who are hard of hearing.

- Other assistive listening devices can be used in group meetings to enhance participation of persons who are hard of hearing (e.g., FM systems, infrared systems).

- Closed caption decoders should be available for TVs used for both recreational and program purposes.

Visual Impairments

Since most persons who are legally blind are quite knowledgeable about their impairments, it is perfectly reasonable for a staff member to ask what help they need in order to get into and fully participate in the program.

Outreach for participants who are visually impaired. How does a person with a visual impairment locate, read about, and get into an alcohol and drug program? Getting the word out and getting the person in could be facilitated by considering these options:

- Advertising and publicity for a program should be made available to agencies serving the blind and visually impaired.
- Three methods of appropriate communication are audio tapes, braille, and large print materials.
- Networking is also effective since many people with visual impairments either are themselves or have family or friends who are connected with some service agency.

Getting to and around in a program is eased when staff give thorough directions. Staff should clearly describe to a person with a visual impairment where the program is located, what transportation is available, and how to get inside the facility itself. Transportation systems that accommodate those with visual impairments should be utilized if possible.

Getting admitted and learning the rules of the house are problems for those with visual impairments because so many programs rely on the printed word. To help overcome some of these difficulties:

- Admission forms should be available in large print or in braille.
- If a signature is required, just place the person's hand on the line where s(he) should sign.
- Since most descriptions of programs are usually printed, braille, large print, or audio should be employed.
- Tapes and braille translations should be released for reviewing at home as well as with envelopes attached marked "Matter for the Blind or Handicapped." They can then be returned by mail postage-free.

Maximizing participation. Although transcribed materials are essential to serving people with visual impairments, there are many more subtle ways in which a program can maximize the participation of these clients:

- Once inside a facility, a person with a visual impairment needs to be oriented. What are some of the point locators in the facility? Is the coffee pot near the television? Are there low tables in the rooms? A brief but thorough tour of the

facility is essential.

- If structural barriers require reconstruction or renovation, there are many structural problems which do not require much effort to alleviate. Example: it is helpful to paint contrasting colors on the edges of steps, and to make sure there is good lighting.

- Emergency procedures should be explained and available on tape.

- Awareness of the daily routines and schedules can be made available through audio tapes with players that have earphones.

- It should be re-emphasized that it is appropriate to ask a person with a visual impairment what is helpful to him or her.

- When assisting a person with a visual impairment, guide by offering your arm and allowing the person to follow your lead.

- If the program follows the AA model, the General Services Office of AA has the "Big Book" in braille.

Traumatic Brain Injury

"The overall goal of an effective treatment program for a person with a head injury should be total abstinence rather than controlled use." (Blackerby & Baumgarten, 1990)

The National Head Injury Foundation White Paper Report (1988) has outlined many components that are believed to be helpful in the treatment of head injury and substance abuse. They are to include: staff trained in the area of head injury rehabilitation and substance abuse counseling, active family involvement, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) support groups, counseling, environmental control, behavioral intervention, and psychopharmacological management. Also included in this report is a revised version of the twelve steps of AA in a language that is more comprehensible for persons with a head injury. (See Appendix A.)

The traditional 28- to 40-day substance abuse treatment program has not been very beneficial to the person with traumatic brain injury. According to Peterman (1987), there are many reasons why the traditional treatment approach has very poor results with persons with a head injury. The following are some of the reasons given:

- These programs are too fast paced.

- They require writing and memory skills that are far beyond the capabilities of most individuals with head injuries.

- They are generally too abstract and in a conceptual framework.

- Most are inaccessible.

- There is a predetermined time frame as to the length of treatment.

However, with some modification these programs could be made more accessible and effective for individuals with traumatic brain injury. Ideally, building a substance abuse treatment component into the total head injury rehabilitation program would be the best starting point. The following are some recommendations that could be used to improve or develop a substance abuse treatment program for individuals with traumatic head injury:

- It is not realistic to predetermine the length of time a patient will receive treatment. (Persons with a head injury generally take longer to absorb, process, and generalize material.)

- The primary counselor should be a certified chemical dependency practitioner. This person should also be trained in head injury rehabilitation. The training provided to the substance abuse counselor should include organic-based denial, problems with initiation, decreased motivation, etc.

- A section of this treatment program should address the effects of substances on the head injured person. Since many clients are taking prescription medication (anti-seizure medication), the danger of combining alcohol or other central nervous system depressants should be explained.

- Provide clarification as to how community support groups function (AA/NA). Provide meaningful and more concrete explanations of the many abstract elements of these groups.

- Don't assume that reading, vocabulary, and comprehension skills are at the appropriate level of your client. (Memory strategies taught in cognitive retraining classes are excellent tools for learning the steps.)

- Be aware of why support groups work so well at sustaining sobriety. The benefit derived from **working the steps** and studying the **big book** is great, but many persons with head injuries will not grasp these aspects of the program. However, there are other elements of AA that one with significant cognitive impairments can tap into and benefit from. The social, fellowship, peer support dynamics and the commitment to attend and abstain are strong elements adding to successful recovery (Peterman, 1987).

- AA and NA groups should be selected on their open-mindedness and tolerance. A beginners' group will usually have these group qualities.

- Provide a treatment program that includes active family involvement (family systems based).

- Provide training in behavioral and stimulus control techniques,

- Provide pharmacological support,
- Adhere to a holistic rehabilitation treatment philosophy,
- Provide adaptations for cognitive impairments,
- Provide structured aftercare programming.
- As part of the patient education process, drawing parallels between some effects of head injury and the effects of central nervous system depressants may be helpful to clients in choosing a drug-free life style. Table VI-1 below indicates the similarity between a depressant and head injury.

Table VI-1
Interaction Between Head Injuries and Depressants

Possible Effect of Head Injury	Effects of Central Nervous System Depressants
Poor memory	Poor memory
Impaired judgement	Impaired judgement
Fine and gross motor impairments	Fine and gross motor impairments
Poor concentration	Poor concentration
Decreased impulse control	Decreased impulse control
Impaired language skills	Impaired language skills

(Peterman, 1987)

Many individuals with substance abuse histories may benefit from traditional drug and alcohol rehabilitation treatment programs. However, these programs are not designed to address the physical and cognitive limitations of those who have sustained a head injury. Should the necessity of such programs be considered, it is crucial that program personnel be fully advised of the medical, cognitive, and psychological problems of persons with a head injury to ensure that their needs are met.

Psychiatric Disorders

What would a model substance abuse treatment program for persons with mental illness look like? What are the most important components of a such a program? Does one presently exist? These are a few of the questions that need to be addressed.

There are a number of different approaches being used today to treat persons with psychiatric disorders and substance abuse problems, and many of these approaches have some

success. However there is no consensus as to the best or most effective approach. One of the major controversies among the programs involves the treatment goal. Some programs emphasize total abstinence, while others emphasize controlled use. In addition to differing opinions on the goal of treatment, there exists a variety of treatment approaches.

Symptom model. This traditional approach believes that the person's substance abuse problem is a symptom of, or a response to, a psychiatric or family disorder. If the underlying problem is successfully treated the substance abuse will disappear.

Self-medication model. This model states that the substance abuser uses chemicals in a well-meaning, but problematic, way to alleviate or manage psychiatric symptoms.

Independent problem model. This approach views substance abuse or dependency as an independent problem. Under this rubric, there are a number of treatment approaches used to address this approach:

- Behavioral intervention which may include aversive conditioning, skill training, and behavior modification training.

- Medication approach which includes antabuse, or methadone. NOTE: Extreme caution must be used when prescribing antabuse or methadone with clients who have mental disabilities. Some say it is counter indicated for fear of misuse. Misuse of antabuse by someone with a mental disability could prove fatal.

Education model. A commonly used approach is the educational approach. This may be used separately or in combination with a variety of other approaches. The intent is to motivate the client to change his/her chemical use pattern.

Recovery model. The Recovery Model's treatment approach and philosophy believe that substance abuse and dependency is a disease. Individuals are treated as "sick people getting well," rather than "bad people getting good." This model believes that an abuser is never "recovered," but instead is "recovering"; abstinence is mandatory before recovery can begin; the concept of addiction and cross-tolerance must be learned; and the disease of addiction is progressive and fatal. The cornerstone of this model is Alcoholics and Narcotics Anonymous and the twelve steps.

The mental health model. This model takes into account the many different problems and approaches taken within the field of mental health. Another name for this model could be the bio-psychosocial model. This approach views that psychiatric disorders have biological, psychological, and sociological components and that these components are included in both the cause and consequence of the disorder. The belief is that psychiatric disorders are complex and require a comprehensive intervention. This model follows a set of seven strategies and approaches for intervention:

1. Correcting physiological deficiencies through such approaches as medication, nutritional supplements, and even exercise.

2. Building social support systems through such things as case management, attendance at special issue support groups, and mobilization of friendship networks.

3. Improving family functioning through education about the disorder, communication skills training, and negotiation of contracts regarding roles, boundaries, and consequences for specified behaviors.

4. Prompting and reinforcing positive behavior through such tools as reminder cards, behavior checklists, and point systems.

5. Increasing the client's functional abilities through the teaching of such skills as assertion, stress management, or activities of daily living such as taking the bus or cooking a meal.

6. Encouraging productive thinking patterns through education about the nature of the disorder, using positive self-talk and imagery, or examining faulty assumptions about self and others.

7. Increasing client awareness of feelings, thoughts, and behaviors and their interrelationship through such methods as exploring the relationship between family of origin issues and current behavior, commenting on here-and-now behavior in group therapy, and keeping journals.

Selecting and sequencing the appropriate interventions requires a careful assessment of the client's current functioning level, the manifestation of the specific disorder, and the specific situation of the client, (Evans & Sullivan, 1990).

Recovery based approach model. One of the newest models in substance abuse treatment is the Recovery-Based Approach which blends the Mental Health Model with the Recovery Model. These two models have a number of similarities that will allow the mental health profession and the chemical dependency profession to unite in their treatment efforts. Their similarities are as follows: both function in a bio-psycho-sociological mode, believe in a genetic basis and disease process, utilize psychotherapy, seek to change attitudes and defenses, emphasize family and social support, believe in AA/NA and other support groups, believe in correcting chemical imbalances, believe in educating the client about the disease concept and knowledge about neuropsychological impairments associated with psychiatric disorders. Table VI-2 lists the views of the recovery and mental health models of substance abuse treatment.

In addition to the programmatic similarities, the following components of a substance abuse treatment program for individuals with coexisting disabilities (specifically mental illness and substance abuse) are recommended:

1. **A comprehensive assessment**. A comprehensive assessment is needed to establish a differential diagnosis between psychiatric disorders and substance abuse. Most of the inaccuracies in diagnosing mentally ill substance abusers have resulted from

Table VI-2
Comparison of Recovery and Mental Health Models

RECOVERY MODEL Disease Process	MENTAL HEALTH MODEL Syndrome Concept
Bio-psychosocial/spiritual factors	Bio-psychosocial factors, some attention to philosophical issues
Chronic condition	Chronic condition of many major disorders
Relapse issues	Relapse issues
Genetic/physiological component	Genetic/physiological component in many disorders
Chemical use primary	Psychiatric disorder primary
Out of control	Ineffective coping
Denial	Poor insight
Despair	Demoralization
Family issues	Family issues
Social stigma	Social stigma
Abstinence early goal	Stability early goal
Recovery long-term goal	Rehabilitation long-term goal
Powerless	Empowerment
No use of mood altering chemicals	Psychotropic medications used
Education about illness	Education about illness
Halfway houses, AL-ANON clubs	Group homes, day treatment
Sponsors	Case manager/therapist
AA, Al-Anon, Self-help groups	Support groups
Concrete action	Behavior change
Self-examination and acceptance	Awareness and insight
Label self as alcoholic/addict	See self as whole person with a disorder
Practice of communication and social skills	Practice of communication and social skills

Table VI-2 (continued)
Comparison of Recovery and Mental Health Models

RECOVERY MODEL Disease Process	MENTAL HEALTH MODEL Syndrome Concept
Slogans, stories, affirmation	Positive self-talk, imagery
Stepwork	Psychotherapy
Use of spiritual concepts	Use of existential, transpersonal concepts
Family therapy	Family therapy
Group and individual work	Group and individual work
Continuum of care	Continuum of care
Nutrition, exercise, growth as value	Wellness concepts

(Evans & Sullivan, 1990)

addictive diseases mimicking psychiatric disorders. Professionals often fail to discern that some of the symptoms of substance abuse parallel psychiatric symptomatology and, as a result, clients are often misdiagnosed. This misdiagnosis leads to incorrect treatment procedures.

2. **Use of medication**. The use of psychotropic medication is condoned provided a comprehensive assessment has been made and such treatment is warranted. However, clients need to be educated in the difference between appropriate medications and usage and addictive medication. The use of addictive medication following detoxification is prohibited.

3. **Abstinence**. The necessary goal of treatment is total abstinence from all mind altering substances. Research has indicated that chemical usage of any kind can escalate symptomatology and add a new set of difficulties to individuals with psychiatric disorders.

4. **Self-help groups**. These groups can provide social support that can assist the individuals to maintain abstinence and stability in association to their psychiatric disorder. They also provide an opportunity for socialization, an environment to develop social skills, and explore distorted thinking patterns that are affiliated with their psychiatric disorder.

5. **Modified twelve-step process**. A modified version of the original twelve-step process needs to be utilized that has considered the clients' abilities to understand and process the information.

6. **Spirituality**. This concept is utilized to assist the substance abusers in understanding that they are not alone; that there is help and hope; that things will improve; and that their will power alone will not be enough. Persons with psychiatric disorders, especially thought disorders, may find these concepts quite difficult to grasp. A more practical and concrete discussion which focuses the clients' development of faith as it relates to how things are better today than they were in the past and how someone or something else can help them is often helpful.

7. **Confrontation versus supportive approach**. As a general rule of thumb, the notion of direct confrontation is counterproductive and at times quite harmful to the clients. Instead, a more supportive approach where the clients' "thinking errors" are discussed as a means of holding them accountable for their behaviors is preferable.

Many of the recommendations provided are quite similar to those provided in the section on traumatic brain injury. Both disabilities have cognitive deficits that need to be addressed when substance abuse treatment is under consideration.

DISABILITY AWARENESS TRAINING

Disability awareness training needs to be provided for everyone in the treatment program. It can provide both the substance abuse clients as well as the clients with coexisting disabilities the opportunity to explore and understand each other by creating an environment in which questions related to specific disability concerns can be asked.

For persons with a disability, the two components of substance abuse and the disabling condition may never have been separated. A disability awareness training session may allow the individuals to become aware of how substance abuse has impacted on their lives in relation to their disability. Some persons with physical or mental disabilities who are abusing substances have learned to be helpless, expecting that people will take care of and provide for them. The treatment group needs to understand what the individuals with a coexisting disability can reasonably be expected to do for themselves. The treatment group can then use this knowledge to confront the individuals if they try to use their disability to leave treatment, avoid doing things that are uncomfortable for them, or manipulate others into taking responsibility for his/her life. This may be the first time in the individual's life that the two components of disability and substance abuse have ever been separated so that the effects of each can be observed.

Training of Substance Abuse Program Staff

Most treatment programs have many professional staff, including counselors, nurses, physicians, occupational therapists, physical therapists, and support staff (maintenance, front desk, and secretarial staff). The minimum recommendations for adequate programmatic development may consist of a Certified Chemical Dependency Practitioner (CCDP), a qualified rehabilitation counselor, and peer counselors. The best peer counselors would be persons with physical or mental disabilities who are also recovering substance abusers.

It is recommended that all staff of substance abuse programs (from front desk to therapists) be provided training in disability awareness. If the program serves a predominance of a specific disability, additional specific training is appropriate. General information and training should be centered around what it is like to work with people who have disabilities, the things that you don't need to be afraid to say, how to assist a person with a disability, and when is it OK to offer assistance or when is it not.

The availability of clinical assistance or supervision is very important in any program. This will allow the staff to field questions, concerns, and uncertainties to each other and/or the supervisors. Some common concerns that may arise are: "I don't know whether they are using their disability to manipulate their way out of this."; "Is he/she being lazy or is it the effects of their head injury?"; or "Is he/she using drugs again, or are these symptoms of the disability?"

Staff training at substance abuse programs should be experiential as well as didactic. A model staff training program may include some personal values clarification, exposure to several treatment programs, and specific educational topics.

The following is a list of suggested questions which should be covered in training substance abuse treatment staff who wish to learn about the special needs of substance abusers who have an additional disability. Each question might serve as a unit in such training.

1. What do they need to know about vocational rehabilitation and its ways of serving people? Eligibility (particularly feasibility) versus entitlement.

2. What is the psychological impact of the other disability on the substance abuse treatment process?

3. What are the physical, cognitive, and medical needs of persons who have a disability in addition to the substance abuse? (List the more common coexisting disabilities as covered in this report.)

4. What should treatment persons know about accessibility needs and issues? What accommodations will they need to make in their particular programs (physical plant, schedule).

5. What are treatment staff attitudes that can negatively impact treatment of coexisting disability clients?

6. What do treatment persons and rehabilitation persons need to communicate about? When are joint staffings needed? When should the client be involved (present) in these communications and staffings?

7. What are the special family and co-dependency issues that can arise when the client is an abuser with a coexisting disability? How are these to be addressed and by whom?

8. What are the special aftercare (continuing) needs of these clients that both agencies should consider and assist the client in planning for?

Training of Vocational Rehabilitation Professional Staff

It is suggested that in-service training be developed by each state vocational rehabilitation agency to fit their particular needs. At the end of that training vocational rehabilitation counselors should be able to answer the following questions:

1. What is addiction? What are its symptoms and usual course of development? How is "abuse" different from "use"?

2. What are the most commonly abused drugs (including medications) and what are their effects?

3. What part does the family play in the development and continuance of addiction and in its treatment? How can the vocational rehabilitation counselor make use of the family in the rehabilitation process?

4. What is meant by denial, and how can counselors minimize or counteract its effects?

5. What is relapse, and how should counselors respond to it?

6. What effects do counselor attitudes toward addiction have on the rehabilitation of substance abusers?

7. What are the professional and personal needs of counselors who work with substance abusers, and how can these be met? Whose responsibility is this?

8. In what ways do the vocational rehabilitation counselors need to work cooperatively with the treatment personnel?

9. What questions should be asked by the counselor in the intake interview? When is additional assessment needed and what kinds?

10. What do vocational rehabilitation counselors need to know about how the various other disabilities interact with the substance abuse?

11. What constitutes substance abuse treatment, its elements, and process? What specific programs are available to counselors and how can they be accessed?

12. What do counselors need to know about the confidentiality law and how to communicate legally between agencies and persons?

13. What are the multicultural issues that need to be known and respected in working with substance abusers?

REFERENCES

Blackerby, W. F. & Baumgarten, A. (1990). A model treatment program for the head-injured substance abuser: Preliminary findings. Journal of Head Trauma, 5(3), 47-59.

Cherry, L. (1988). Beyond Ramps: A Guide for Making Alcohol and Drug Programs Accessible. Bay Area Project on Disabilities and Chemical Dependency. San Mateo, CA.

Evans, K., & Sullivan, J. M. (1990). Dual Diagnosis: Counseling the mentally ill substance abuser. New York: Gilford Press.

Madara, E. J., & Meese, A. (Eds). (1990). The self-help sourcebook: Finding and forming mutual aid self-help groups. Denville, NJ: Saint Clares-Riverside Medical Center.

Peterman, W. A. (1987). Substance abuse counseling strategies for head injury survivors. National Head Injury Foundation White Paper (1988). Washington, DC: Substance Abuse Task Force, National Head Injury Foundation - Professional Council.

Schaschl, S., & Straw, D. (1989). Results of a model intervention program for Physically impaired persons. Alcohol Health and Research World, 13(2), 150-153.

Chapter VII

EMPLOYMENT AND PLACEMENT ISSUES

The purpose of this chapter is to present and discuss some of the special considerations in job placement where substance abuse is a co-existing disability. It is assumed that the reader (counselor) should possess information about the vocational implications and placement issues with persons who have disabilities other than substance abuse. Consequently, the focus of this chapter will be on issues related to substance abuse.

POINTS TO CONSIDER

When considering job placement with the client who has a coexisting disability, the vocational rehabilitation counselor should consult with persons who have been treating the client for each of the disabilities. Although treatment personnel may lack the specific job placement skills of the rehabilitation counselor, they probably have knowledge and insights into the consumer's job needs. Job needs may not have been shared earlier because job placement was not the focal point. For example, a client who had always held sales jobs might have admitted in a group session at the alcohol/drug treatment center that he/she had always hated being a salesperson and wanted to be a tax return preparation person (two very different jobs). The client might never have mentioned this to the rehabilitation counselor, since the counselor might never have given him/her the opportunity, just assuming that "once a salesperson, always a salesperson." There are persons who need to consider radical job changes, and such needs might come from within that part of the person that gets exposed only (or easiest) in a therapy group. Some salient points the rehabilitation counselor should consider regarding client's needs are:

- Treat the person with a co-existing disability with the same respect that you would treat any other client.
- Do not treat your clients who have a coexisting disability as if they will automatically fail in the employment setting. Recovering people tend to demonstrate better work habits than nondisabled.
- The counselor and client should discuss aftercare plans with the employer (including confidentiality).
- The counselor should be available to the employer for consultation and referral to an Employee Assistance Program for drug and alcohol abuse assessment.
- Expect your client with a coexisting disability to succeed even though relapses will probably occur along the way.

- Consider jobs that match the client skills and stress tolerance.

- Make certain that community supports and aftercare programs are in place before the client with coexisting disability of substance abuse is placed on a job.

VOCATIONAL IMPLICATIONS

In addition to detoxification, strengthening the ego, increasing self-esteem, and developing a constructive support system, the recovering substance abuser needs to be in a position to return to living in a healthy environment. A healthy environment is one which facilitates independence (minimizes the need for dependence) and reinforces non-enabling behaviors. By the time many substance abusers enter treatment they have lost their job, friends, and family. Consequently, an important aspect of their rehabilitation is return to work in a job that will allow them to support themselves in an environment where they are less susceptible to the influences that originally contributed to their substance abuse. Recovery from long-term substance abuse requires more than a change in the motivation to take a drink or do drugs.

Social vocational status is correlated with physical dependence on drugs or alcohol. Treatment that offers the opportunity for social-vocational change enhances the long-term functioning of persons who abuse alcohol and drugs (Baker & Cannon, 1988).

While work is an important component in maintaining long-term sobriety the type of work environment is also a crucial factor. Newton, Elliott, and Meyer (1988) indicated that a structured work environment, one that is "nonenabling," reduces relapses. This work environment is one that discourages substance-related behaviors as opposed to work environments with minimum structure (i.e.,"enabling" or promote substance abuse). For example, office positions are often highly structured with short work breaks as a group. In other positions, the employees may work independently and take breaks whenever they wish. Thus, these persons have the opportunity to hide their substance abuse. Other groups may meet in a local bar socially at the end of the work day or week.

It is not realistic to expect a newly recovered addict to make the change from treatment to employment without the benefit of professional assistance and support (Beale, 1988). Such support is found in job seeking skills groups as suggested by Hall, Sorensen, and Loeb (in Baker & Cannon, 1988) and Beale (1988). Others require continued attendance at support group or therapy group meetings.

It is clear from the above discussion that vocational rehabilitation should be an important part of substance abuse treatment. As pointed out by Buxbaum (1988), while substance abuse treatment professionals are quite familiar with the treatment of substance addiction, they are usually unfamiliar with the psychological and social aspects of disabilities and their effect on vocational development. The positions in substance abuse treatment do not require dealing with persons with disabilities in a way that will result in their returning to a productive work situation. Good job placement though will reinforce nonsubstance abusing behavior. Rehabilitation counselors know how to help persons with disabilities return to work but often do not understand the dependence needs which result in relapse on the part of substance abusers.

Consequently, these two agencies need to work together in order to maintain abstinence for persons with existing disabilities. Working together will increase the probability that the person will be successfully rehabilitated.

ATTITUDES IN SUBSTANCE ABUSE TREATMENT

Allen, Peters, and Keating (1982) found that the attitudes of mental health and rehabilitation counselors toward substance abusers was significantly more negative than their attitudes toward homosexuals, public offenders, the mentally retarded, the physically disabled, and the mentally ill. Dudek (1984) indicated that the most important factor in successful intervention with substance abusers is not technique, but attitude. Counselors who do not have experience in working with substance abusers often feel uncomfortable in dealing with them as clients due to reservations concerning the success of their efforts. Effective substance abuse rehabilitation counselors have adopted positive attitudes in three areas regarding treatability of persons who abuse substances: awareness of substance abuse as a problem; the place of relapse in achieving vocational rehabilitation goals; and substance abuse as a legitimate concern in worker's compensation rehabilitation systems.

Awareness

Lett (1988) suggested that rehabilitation counselors without experience in working with persons abusing substances may not recognize significant signs in their client's history. A study of intake counselors in a community-based counseling program, who were trained to be aware of substance abuse, recognized alcohol or drug related problems at a significantly higher rate (60.8%) than untrained counselors (6.1%) (Dahlahauser, Dickman, Emener, & Lewis, 1984).

However, they often feel it is too personal or sensitive an issue to discuss. Even when aware of the problem, rehabilitation counselors often are reluctant to discuss it with their client. When counselors ignore this problem, they are participating in what Greer (1986) refers to as "enabling" behavior. As a result, the client's abuse of substances is reinforced by the counselor's avoidance of the problem. This avoidance behavior on the part of many rehabilitation counselors contrasts with findings reported by Dickman and Phillips (1983) which suggested that of all the disabilities, substance abuse is one of the most treatable. While it is often fatal when left untreated, successful diagnosis and treatment can result in recovery. The attitudes of successful rehabilitation counselors in treating substance abusers reflect this reality.

Relapse

Traditional vocational rehabilitation has emphasized the one-stop approach. Diagnosis, treatment, evaluation, training, and placement are typically expected to result in successful case closure. Failure at any point in the process often leads to termination of the counseling relationship. Nelson (1986) suggested that substance abuse is often characterized by taking two steps backward for every three steps forward. The process of recovery is a lifelong effort in which a support system is crucial to success (Dickman & Phillips, 1983). The rehabilitation counselor can be an important part of this system. However, to function effectively in this role, the counselor should understand that clients may relapse, help them pick up the pieces, and go

from there. A return to substance abuse behavior does not necessarily mean a person is not motivated for vocational rehabilitation. Rather, it may reflect signs that progress is being made toward the goal of dealing with abusing substances.

Hunter and Salomone (1987) suggested that there are symptoms of behavior change, e.g., "dry drunks" (i.e., HALT - hunger, angry, lonely, and tired), that signal when a relapse is about to occur. They reported studies which indicated substance abusers of all types are at the greatest risk of relapse in the first three months of recovery, "with a 50% to 75% rate of relapse within a six to eighteen month follow-up period" (p.23). Rehabilitation counselors, if they are aware of and sensitive to the symptoms that signal imminent relapse, can assist recovering substance abusers in either preventing the relapse or dealing constructively with the event after recovering from the relapse.

Worker's Compensation

A final comment on the importance of attitudes in successful substance abuse counseling relates to substance abuse as a legitimate concern in worker's compensation rehabilitation systems. There appears to be a prevailing attitude that substance abuse should be ignored in favor of the disability that resulted directly from the industrial injury. Substance abuse, which often predates the industrial injury, is not considered a responsibility of the insurance company. Consequently, insurance companies do not want to hear about the problem. Insurance companies fear claims of stress/employment related problems which are difficult to define and deal with from their perspective.

Many rehabilitation counselors are faced with the dilemma of ignoring a problem that, even though it may be secondary to the industrial accident, has the potential for becoming a greater barrier to employment. As a result, the counselor either does not deal with the substance abuse problem or is forced to help the client deal with it on an informal basis while not reporting it to the insurance company. In either case, the underlying message is "don't be sensitive to substance abuse." This negative attitude not only is counterproductive to successful substance abuse counseling but also defies reality. Substance abuse awareness and treatment as an integral part of the rehabilitation plan. It must also become a legitimate part of the worker's compensation rehabilitation system if counselors are to assist their clients achieve successful vocational rehabilitation (Stude, 1990).

Other Counseling Problems

In addition to constructive attitudes on the part of service providers, there are a number of other vocational implications that must be considered by the rehabilitation counselor. Low self-esteem, lack of confidence, and fear of socialization outside of a therapeutic community may result in a feeling of a client's uncomfortableness in a training or work setting. Recovering substance abusers may be attempting to implement new relationships with family members by focusing on caring for others rather than themselves. Concern as to whether the job will meet financial needs may result from this rediscovered responsibility for others. Support groups which focus on the development of problem solving skills will be needed to facilitate reaching the goal of successful vocational rehabilitation (Zavolta & Rogoff, 1990).

Clients who are recovering from substance abuse may exhibit problems in work attitude or behaviors. The road to recovery is a difficult one. In the past they may have relied on manipulation and exhibited immature behavior in dealing with problems. The rehabilitation counselor should be available to help clients recognize this behavior as being inappropriate and assist clients in learning behavior that is more acceptable. The problem of motivation may be further complicated by a past which included making relatively large sums of money either legally or illegally to support their habit. As a result, entry level wages may not seem very appealing. The counselor will need to stress the opportunity that will be afforded clients to increase income with sobriety and job experience.

Mature work personality characteristics such as appropriate grooming, personal hygiene, appropriate relationships with coworkers and supervisors, the ability to delay need gratification, acceptance of criticism, dealing effectively with frustration, and other worker characteristics may have been lost during the period of substance abuse. The rehabilitation counselor will have to exercise patience, yet be willing to interact with clients in regard to relearning these characteristics. Whether to volunteer information about his/her substance history in a work setting may become a problem for the recovering substance abuser. The honesty, openness, and direct confrontational techniques associated with treatment of substance abuse can be overpowering in the work place. Whether or not to disclose previous substance abuse behavior will need to be carefully considered by the counselor and the client with an eye to avoiding evasiveness, defensiveness, and falsifying information (Knowles in Stolov & Clowers, 1981).

Finally, it is important to remember that each person who has a history of substance abuse is different from other abusers. Individual treatments with follow-up after the job has been obtained will give clients who are recovering from substance abuse the greatest opportunity to reach their full potential as independent and responsible individuals in our society.

ESTABLISHING AN AFTERCARE PROGRAM

It is likely that a client's chances for maintaining employment will greatly increase as the period of abstinence from substances lengthens. Abstinence will be more likely if a comprehensive system of support is in place for use by the client. The support needed will promote the gains which have been made in treatment and which will reinforce the treatment philosophy of recovery. It is of primary importance to establish the aftercare plan as a continuum of previous inpatient or outpatient treatment. Systems of support set up independently of previous treatment may conflict with previous treatment philosophy and result in confusion. The confusion may in turn trigger disillusionment, resentment, and eventually relapse. The majority of treatment and recovery programs offers aftercare services as continued support for recovery. These groups usually meet at least once weekly for supportive counseling. These meetings are very important as clients encounter difficulties on the job which were only imagined or talked about while in the treatment setting. Additionally, continued individualized outpatient therapy may be indicated. The need for these services should be determined by the aftercare treatment professional based on the individual client's needs and progress in treatment.

Most inpatient and outpatient treatment programs require active involvement in working a "twelve-step" oriented program in the community with weekly and sometimes more frequent

attendance at meetings. The tenets of AA/NA programs are utilized during the treatment and recovery phase of most programs. Individuals involved in either of these 12-step programs should select and interact with a "sponsor" who has enough sobriety and experience to support and show them the way.

For individuals with mobility restrictions, it is important to link them with a group that is sensitive to accessibility and possibly special transportation needs of the individual. Special transportation needs may be a problem requiring the combined efforts of the vocational rehabilitation counselor, family members, and the AA/NA community. It is equally important to link, as closely as possible, like social and cultured values when considering local groups. Therefore, it is important that the counselor have an awareness of locations of different groups in the community. Networking with local treatment professionals is usually the best way to learn about specific groups and locations.

Job Club

If counselors have identified several individuals on their caseloads with substance abuse diagnosis, it can be very beneficial to make participation in a "job club" part of the continuum of care plan. Individuals can learn a great deal from each other in a job club. This can be particularly beneficial for those individuals who exhibit job readiness but do not yet have firm job leads or prospects. Meetings are held weekly for support related to job seeking skills and generally getting through the system such as practice in obtaining and completing job applications, job interviews and practicing for the job interview.

Job clubs offer an opportunity to voice fears of not performing well and/or the possibility of encountering coworkers who may be substance abusers. If these individuals have previously worked, it is important to talk about job losses that occurred as a result of substance abuse and/or disability onset and how this affected their present attitude and feelings about themselves. For many, the club can offer a forum for learning and practicing how to present themselves in a positive light to potential employers. The job club can help clients become aware of the needed persistence and follow through that are required to get a job.

Denial

Counselors will oftentimes encounter clients who refuse to attend support groups and other recommended recovery meetings. Yet they may be very demanding about wanting a job immediately, as if the job alone will be the cure for their problem. Individuals who exhibit these and other negative attitudes toward addressing their substance abuse are still in denial regarding their recovery. They may tend to feel that someone else should make the job happen for them. They are usually not working with their recovery program and therefore do not have the tools with which to counter the relapse triggers that will occur on and off the job.

Job placement at this stage is probably counterproductive to treatment and ongoing sobriety. These same behaviors can be observed in clients who are going through the motions of attending meetings yet not be in a "recovery mode." This is often observed with individuals with mental retardation as well as individuals with neurological impairments.

Absence of Bonding

Vocational Rehabilitation counselors often encounter adults who began their substance usage during adolescence. It is useful to remember that with the onset of the substance abuse behavior, a number of developmental processes may have been arrested. These include cognitive, emotional, and physical development. Thus, if a counselor is dealing with 30-year-old individuals who began abusing at age 14, they may still be emotionally and cognitively functioning at a 14-year-old level. These individuals often have limited job skills and work experience. Due to early substance use, they may not have experienced the benefit of normal preparatory processes of job seeking and job maintenance.

Individuals with early substance abuse often do not have the skills to obtain and maintain employment. Interpersonal skills may appear immature and limited particularly in the art of negotiation, conversation, and perhaps etiquette. They often have never learned to recognize nor process emotions. Consequently, they have no practice in the exercise of patience, tolerance, or delayed gratification.

For many of these individuals, the first step toward placement may be in a very structured setting. A work oriented rehabilitation facility may be considered where they can develop appropriate working behaviors, communication skills, increased tolerance, and a sense of accomplishment in developing and maintaining these skills over a sustained period of time. This type of situation is usually most beneficial when coupled with a structured living situation such as in a half-way house or 3/4-way house.

PLACEMENT ISSUES

Employment is widely recognized as a major goal of successful treatment of the substance abuser. It is the primary vehicle for reintegrating the client into the community as a productive and contributing member of society. In addition, there is a very strong positive correlation between employment and abstinence from substance abuse after successful treatment.

Before a person can be placed successfully in employment, he/she must have recognized the nature and severity of the substance abuse problem and be committed to on-going treatment to deal with the problem. In addition, the counselor should have addressed several factors. The following is a basic checklist for a rehabilitation counselor preparing a substance abuse client for employment:

1. Has the client acknowledged that he/she is a substance abuser?

2. Is the client willing to attend Alcoholics Anonymous/Narcotic Anonymous and/or enroll in a mental health program or other aftercare program?

3. If a previous unsuccessful client, has the substance abuse pattern or lifestyle changed in a positive direction, i.e., has the client's periods of sobriety lengthened?

4. After having completed the recommended treatment program, has this individual kept scheduled appointments and maintained regular attendance in a therapeutic program such as AA?

5. Are there signs of projection and denial by this individual?

6. Are there unresolved conflicts (e.g., a pending divorce, legal charges, etc.) which need to be resolved before the client can be expected to benefit from employment?

7. Does the client want to enter or re-enter gainful employment?

8. Is the level of physical disability so severe as indicated by medical reports that the individual will not benefit from vocational rehabilitation services in terms of employability?

9. If related physical problems are present, what functional limitations do they impose and what is the prognosis for their remediation?

10. If severe underlying emotional or psychiatric problems are present, is this individual ready for a vocational rehabilitation program or is additional treatment necessary before employment should be considered?

11. Has the issue of educating the employer about substance abuse been resolved?

12. Have confidentiality issues been discussed with a clear understanding of what will be disclosed to the employer and by whom?

In some cases, the counselor may provide coaching in application procedures, suggest places where the client can obtain job leads, and expect the client to do the rest. At the other end of the continuum is the client for whom all arrangements must be made with the employer and who will require direct involvement of the counselor during the initial stages of adjustment to employment. Appropriate counselor intervention might include convincing the employer that the client is now capable of doing the job, working out a related job that the client can perform, or modifying the job site so that the client can perform the work.

JOB DEVELOPMENT, PLACEMENT, AND FOLLOW-UP

The counselor's involvement in placing the substance abuse client in an appropriate job will vary with each case. As with any person, responsibility for obtaining the job should be assigned as clearly and as early in the process as possible. The consumer should be assigned as much of the responsibility as is reasonable. A general goal of any rehabilitation program is to render the client maximally independent. Sometimes that may involve a "weaning" process to resolve the client's dependence on the counselor or to transfer the dependence to an appropriate long-term resource.

However, most substance abuse clients have less difficulty in getting a job than in keeping jobs. Experienced rehabilitation professionals have long recognized that increased interest and commitment result when clients finds their own job after having been provided counseling.

Particularly when substance abuse began early, many clients have little or no work history and therefore do not have rudimentary knowledge of the job-seeking process. With such individuals, the counselor will need to provide or arrange for instruction in completing job applications; conducting interviews and following-up on interviews; and explaining an unstable employment history, frequent hospitalizations for treatment, and legal involvements.

Particularly with clients whose substance abuse developed rather late in life, previous levels of employment success may not now be realistic. Much of the effectiveness of job placement consists of counseling and guidance to enable the client to realize that he/she may need to perform, at least temporarily, at a lower level of employment than that at which they are accustomed.

In developing jobs and placing clients, the counselor should cautiously approach jobs in which the client has easy access to alcohol/drugs or in which substance abuse is an acceptable and important part of the social milieu. If past substance problems have been associated with job-related stress, such stressful occupations should likewise be avoided. Some of the physical ailments associated with a long history of substance abuse can also cause limitations on employment which the counselor must consider. In any case, the client's active involvement in job placement help give a sense of personal responsibility for performance on the job.

Postemployment Groups

Social competence has been shown to be positively related to work adjustment. It has been found that employers of low-skill, entry level workers were most likely to terminate employees for antisocial and irresponsible behavior in the work place. In order to facilitate the client's adjustment to the world of work and to reinforce the social and coping skills related to maintaining employment, post-employment groups should be held weekly. Issues addressed in these groups include appropriate behavior in the work place; handling anger, stress, and frustration on the job; and time-management. Off-job concerns such as budgeting and financial planning should also be addressed.

Job retention is enhanced when there is frequent counselor/client contact just after placement. Give the new employee positive strokes, help that person keep in perspective the feelings of stress that normally accompany starting a new job, and make sure therapeutic regimens (i.e., AA, support groups) are followed. Also be sure significant others are available and informed about how to provide support to the client and how to seek an outlet for expression of their own problems. The counselor should visit the work site to negotiate solutions to problems. The counselor should also be available to help the employer with termination of the client if necessary, but, in general, to work for employer support of the employee.

CASE STUDIES

The three case studies that follow will allow the counselor to review a client's case process and make some suggestions or observations on how the case was handled.

Case Study I

Alice is a 33-year-old African American, single mother of two with diagnoses of alcohol dependence, cocaine dependence, and personality disorder with borderline and dependent features. She is a licensed cosmetologist with 15 years experience. She describes her skill level as excellent and enjoys the work tremendously.

At the time of referral, Alice had been recently discharged from a drug treatment facility and had entered a structured residential facility in the community. This was Alice's third inpatient treatment for psychoactive drug dependence, but her first experience in a halfway house. She stated that she recognized a need for structure as she had lost her job and her independent living situation with her children due to active addiction. Her reported experience with drugs began at age 13 with drinking alcohol to cope with shyness. She progressed to marijuana and eventually to cocaine. She reported that she had made several suicide attempts after trying repeatedly to avoid drugs but had felt that it was hopeless. She had not been employed for the last seven months. Her children were being cared for by her parents.

In preparation for Alice's return to work, the vocational rehabilitation counselor covered: routine counseling regarding the techniques of effective job search; preparing for the job interview including answering difficult questions; and presenting a sense of what she could realistically accomplish in the work place. The counselor also spent a great deal of time talking with Alice about appropriate self-disclosure with supervisors and coworkers. Another area of intensive counseling involved developing a strategy for handling stress associated with difficult patrons as this was sure to occur.

Alice clearly had extensive experience in her chosen field of work. Yet the counselor reviewed all aspects of the job requirements as a cosmetologist in an attempt to unveil any and all areas that might pose problems to Alice's ability to continue her recovery program. Work hours became a major area of concern. In the cosmetology industry, employees are often required to work past 5:00 p.m. in order to meet the needs of the day-working public. Alice was reminded that she could not accept a job requiring her to work past 5:30 p.m. and maintain compliance with half-way house rules. She was also aware of her commitment to maintain her continuum of care plan which included nightly AA/NA meetings and weekly individual therapy. Alice and the rehabilitation counselor rehearsed her answers to questions from the employer regarding her evening treatment commitments.

Alice was called to report to work within two weeks of her initial interview. The

counselor informed Alice that the first few weeks would be the most crucial in challenging her ability to adjust to the work situation, coworkers, patrons, and supervisors. Anger and frustration were triggers for Alice's return to drug usage. The counselor worked intensely with Alice regarding a plan for handling these feelings during and after working hours.

During Alice's first week, a crucial problem occurred that angered Alice to the point that she was ready to quit her job. Alice learned that her employer did not approve of her passing out her business cards to potential customers because she feared this would attract clientele that her established customers would not approve. Fortunately, the rehabilitation counselor had prepared Alice for the potential conflicts and potentially devastating emotional responses that might occur as a result. Alice called the counselor as she recognized these feelings and got the support she needed to get her through the day.

As Alice progressed with her job, the supervisor shared more about her receptiveness to work hour requirements and discussed the possibility of training to update her skills in new techniques. Alice was somewhat overwhelmed with the display of confidence by her employer. Even though positive things were happening, she was unclear about what her employer expected from her, and she became quite anxious when her employer did not explain possible advancement opportunities. After discussing her anxiety, which was actually covering fear about possible failure, Alice and the counselor rehearsed her approach to her employer about the need for a clearer understanding of expectations. Alice agreed to call the counselor if she felt her emotions were out of control resulting in a potentially impulsive, rash approach to her supervisor.

Alice's need for clarity and limits was resolved with her supervisor, and she has continued on the job for three months without relapse. She continues to learn to use new tools to deal with difficult situations whereas she formerly turned to drugs. She has been able to utilize group therapy to further explore her feelings and has learned new options for dealing with them. She has also continued her twelve-step program, communicating frequently with her sponsor between meetings. She continues to maintain weekly contact with her rehabilitation counselor.

Case Study II

Malinda is a 30-year-old white, single mother of one with diagnoses of alcohol dependence, depressive disorder, and mild mental retardation. She completed the seventh grade and has basic academic skills below the third grade. She grew up in a very rural area. As a child, she was subjected to physical abuse and was consequently removed from her home and placed in foster care. She began drinking at age 18. During her history of drinking, her longest period of sobriety had been for six months following the news from a local clinic that she was pregnant. She spent most of her time drinking with family members. She had been arrested for assault and public intoxication. Additionally, her son was

placed in foster care due to her abuse of him. However, she has no recollection of abusing her son due to her intoxicated state.

Just prior to referral, Malinda had been discharged from a 28-day treatment program and had entered a halfway house. Her work experience was limited to seasonal farm work for five years. The counselor arranged for a vocational evaluation which indicated interests in housekeeping and kitchen helper types of work. The counselor felt that Malinda's limited work history, poor judgement, and chemical abuse would make it essential to seek an employer who would work closely with Malinda in a supportive manner that other employees might not require. The counselor talked with Malinda about informing the employer of her difficulties and giving the counselor permission to discuss her limitations and special needs as well. Malinda was open to this since she had developed a trusting relationship with her counselor. An on-the-job training contract was developed with an employer, who was very sensitive to Malinda's needs. The employer trained her to prepare foods for cooking, make simple salads and desserts, perform tasks on the serving line, and do general cleaning. Malinda was counseled about the importance of asking questions of her employer for assistance when needed and to immediately call her counselor if there were problems that she and her supervisor could not handle.

Malinda progressed without incident on the job. However, she was terminated from the halfway house due to a rule violation for taking a cold medication that contained alcohol. She knew that all medications had to approved and dispensed by the house staff. The counselor quickly arranged for placement in a local shelter and after a short stay, arranged a more permanent living arrangement in a rooming house. With Malinda's permission, the counselor informed the employer as events occurred. The counselor and employer talked with Malinda and offered a great deal of support for her continuing her AA meetings and renewing contact with her sponsor. Being knowledgeable of Malinda's situation, the employer gave frequent verbal praise and support for her performance at work and assured Malinda that she had a job so long as she maintained her rate of performance.

Malinda did well for the following two months before relapsing again. After a two-day absence from work, the employer called the counselor, and once again both the employer and counselor intervened in a timely manner. The counselor worked with Malinda, encouraging her to get a new sponsor who could spend time with her and take her to meetings. Malinda was able to obtain a sponsor who was more attentive to her transportation needs; Malinda has continued attending meetings and has worked for the past several months.

Malinda's primary goal is to regain custody of her son. She realizes that in order to do this, she must maintain her sobriety; and in order to maintain sobriety, she must continue working with her twelve-step program.

Case Study III

Ted was referred to vocational rehabilitation following a motorcycle accident which left him paralyzed from the waist down. He had a good work history in electronics assembly. He wanted to enter a computer training program. Computer Aptitude Testing designed especially for persons with spinal cord and traumatic brain injury indicated his ability to complete the program.

In the meantime, Ted asked to be referred to a physician because of a possible kidney infection. Test results indicated a possible urinary tract infection and possible hepatitis. The doctor also commented that he felt Ted might be drinking more alcohol than he admitted. The counselor talked with Ted about the report and the possibility of treatment for an alcohol problem, and Ted denied such a problem.

Hepatitis was ruled out and Ted's urinary problem improved. Ted was accepted into the computer training program. On the day that he was to begin computer training, he called the counselor to report that he had been in a residential treatment program for addiction for the past two weeks and would be there for two additional weeks.

> **NOTE:** Entrance to computer training should have been contingent on evaluation of an alcohol problem by a qualified treatment professional.

Ted's counselor visited him at the treatment center. Ted said he increased his drinking recently when he and his girlfriend broke up. The counselor commented that Ted tended to blame his problems on other people and situations. The counselor talked with him about this attitude, suggesting that Ted accept responsibility for his own decisions, behavior, and for getting whatever help he needed. Ted was encouraged to call the counselor when discharged from the addiction center (a private treatment center).

Ted came to the counselor's office about five weeks later, looking good and seeming to feel much better about himself. He was encouraged to continue his sobriety and to think toward computer schooling at next entry time.

> **NOTE:** Counselor should have made computer training contingent on client's active participation in all aspects of aftercare plan.

About four months later, Ted called his counselor to report he had recently been treated again for his addiction, this time at a public inpatient program (his insurance would not pay for a second treatment at a private facility). He said things just really went bad for him and he started drinking again and had to be admitted for more treatment. Ted had recently begun working with an uncle getting some experience with computers and was anticipating entry into the computer school when possible. He was encouraged to remain alcohol-free and continue working with the uncle, but there is no mention in the record that he was

encouraged to enter any type of support program to continue dealing with his addiction problem.

> **NOTE:** Vocational rehabilitation sponsorship should be contingent on active participation in aftercare treatment...not just sobriety.

Two months later, the counselor contacted Ted and found that he was doing well, continuing to work with his uncle, and was involved in Alcoholics Anonymous. Three months later, Ted entered the computer training program, living in the school's dormitory. The vocational rehabilitation paid for his training and provided miscellaneous expense money for the duration of his training. He also maintained an apartment in the same city, with the help of his SSDI check, for times when he was not in the dormitory. He expressed a very positive attitude toward AA and continued to attend meetings.

Ted made progress in the computer training, proved to be "independent and somewhat of a maverick," but followed the rules. Ted reported continued involvement with AA, although the counselor knew he had gone to places where alcohol was served. Ted had been told that sponsorship of his training would be stopped if he began drinking again.

Ted completed the eight-week fundamentals course, but his instructor reported that Ted continued to want to do things his own way, would leave school without permission, and had difficulty sticking to limits set on him. There were reports that he was staying out late at night and going to local clubs.

Ted returned to school intoxicated after a major holiday. He went through a brief detox period at the comprehensive center and was prescribed Valium. Ted reported to his counselor that a number of personal problems led to his relapse into drinking and hoped he would not be dropped from school.

The counselor met with Ted for two counseling sessions at the end of his detox week. He had been allowed to remain in school, but was on probation for the remainder of the training. Ted began to talk more personally with his counselor about troublesome issues in his life. He had some relationship problems with "significant others"; he was unrealistic and overly hard on himself regarding goal-setting; he wanted to be the best computer programmer around, wanted to drive an expensive sports car or none at all, etc. Counseling sessions continued on a regular basis, and his self-concept became a focal point. He had no job, no money, no car, and no girlfriend in his life (and doubted that he could have). He was pretty much drowning in self-pity. Interestingly, he did not admit feeling that his paraplegia was an impairment in meeting and maintaining a relationship with girls. Instead he seemed to feel that he should establish instant close relationships with girls. He admitted to being a perfectionist. The counselor pointed out how he was setting himself up for repeated failures by expecting so much of himself (a common characteristic of addicted persons).

Ted seemed to be doing much better in his training, seemed cheerful, and reported resolving some of the discussed problems. His vocational rehabilitation counselor expressed some questions about Ted's ability to maintain his sobriety. The counselor was afraid certain stresses might prod Ted into drinking again. Even so, Ted continued to visit places where alcohol was served.

Ted went home for the Thanksgiving holiday and reported back a day late, telling a fellow student by phone that he had the flu. There continued to be concern about his ability to stay sober. He was having some trouble because he was a perfectionist and was reluctant to ask for help in his schooling, resulting in a badly done project and some confrontation about it.

Ted began submitting employment applications. He had some concerns that the two treatment admissions for alcoholism might hurt his chances, though he had no police record. After several interviews, he was employed as a computer programmer at a salary of $20,000 annually. After over two months of successful employment, and with his approval, Ted's case was closed, rehabilitated. Ted was 28 years old at the time of his referral for services. Almost three years passed from the time of his referral until his case was successfully closed.

Several Things of Interest About This Case

1. Although it had its ups and downs, it became a successfully closed case. Progress with substance abuse cases often is not smooth or steady, but this does not mean there is no progress.

2. The vocational rehabilitation counselor maintained good contact with this client, especially during times of crisis when there was expressed need on the client's part or when special need was felt by the counselor. The counselor continued to remind the client of the agreed-upon goals and what was expected of him if the plan was to succeed. Encouragement was given and there was a relationship of relative honesty and directness between counselor and client. They were not just "nice" to each other.

3. Neither admission for alcoholism treatment was known to the counselor until after the fact. A lot was hidden from the counselor by the client until after the second admission, when their relationship seemed to become more meaningful and important. The counselor did encourage the client to remain in AA and reminded him that sobriety would be required of him if VR was to continue to sponsor his training.

4. Even toward the last of the rehabilitation effort, the counselor had some doubts about his client's ability to maintain sobriety and be successful in training (and employment), and there were some valid reasons for his doubt. Recovery from addiction is not a rapid, sure thing, and relapses should not be surprising. They can, however, be accepted as just part of

the recovery process, as in this case.

5. Ted was typical of many alcoholics in a number of ways. He tended to be a perfectionist (stemming from more basic low self-esteem). He had difficulty in establishing close relationships, especially with members of the opposite sex. He had difficulty following stated ways of doing things, tending to do it his own way, even when his own way did not work. He had some problems relating to "authority figures," such as instructors. It was hard for him to get to the place where he could talk directly about personal feelings, and he tended to blame others for his problems until he did begin dealing openly with some basic issues in his life. He did have significant strengths and actually demonstrated much courage and motivation. He denied his addiction at first, but did get the help he needed, and he did learn to use aftercare counseling and fellowship of AA for growth and support.

6. Obviously, the future is uncertain. Ted does not "have it made." There will be continued times of stress and walking "on the edge" at times, as when he visits places where drinks are served. Addiction is a chronic condition and knows no quick solutions. But, Ted has accomplished much for himself, and he has that to remember as he faces the dangers and the opportunities of the future. It can be also said that his rehabilitation counselor learned about addiction recovery through this case and deserves commendation for the overall job. He showed, like his client, an ability to learn and not to give up. They made a good pair.

REFERENCES

Allen, H. A., Peters, J. S. & Keating, G. (1982). Attitudes of counselors toward the alcoholic. Rehabilitation Counseling Bulletin, 25(3), 162-164.

Baker, T. B. & Cannon, D. S. (1988). Assessment and treatment of addictive disorders. New York: Praeger.

Beale, A. V. (1988). A replicable program for teaching job interview skills to recovering substance abusers. Journal of Applied Rehabilitation Counseling, 19(1), 47-49.

Buxbaum, J. (1988). Helping the disabled alcohol-dependent client: A training program for rehabilitation counselors. Rehabilitation Education, 2(2), 113-119.

Dahlahauser, H. P., Dickman, F., Emener, W. G., & Lewis, B. Y. (1984). Alcohol and drug abuse awareness: Implications for intake interviewing. Journal of Applied Rehabilitation Counseling, 15(4), 31-34.

Dickman, F. & Phillips, E. A. (1983). Alcoholism: A pervasive rehabilitation counseling issue. Journal of Applied Rehabilitation Counseling, 14(3), 40-45.

Dudek, F. A. (1984). Rehabilitation counseling with alcoholics. Journal of Applied Rehabilitation Counseling, 15(2), 16-21.

Greer, B. G. (1986). Substance abuse among people with disabilities: A problem of too much accessibility. Journal of Rehabilitation, 52(1), 34-38.

Hall, S. M., Sorensen, J. L., & Loeb, P. C. (1988). Development and diffusion of a skills training intervention. In T. B. Baker & D. S. Cannon (Eds.), Assessment and Treatment of Addictive Disorders (pp 180-204). New York: Praeger.

Hunter, T. A., & Salomone P. R. (1987). Dry drunk symptoms and alcohol relapse. Journal of Applied Rehabilitation Counseling, 18(1), 22-25.

Knowles, R. R. (1981). Drug abuse. In W. C. Stolov & M. R. Clowers (Eds.), Handbook of severe disability: A text for rehabilitation counselors, other vocational practitioners, and allied health professionals (pp.241-252). Washington, DC: U.S. Department of Education, Rehabilitation Services Administration.

Lett, P. (1988). Dual diagnosis: Psychiatric disorder and substance abuse. Journal of Applied Rehabilitation Counseling, 19(2), 16-20.

Michael, J. H., Miller, J. H., & Mulkey, S. W. Vocational Rehabilitation and Chemically Dependent Youth. Eligibility Determination and the IWRP.

Nelson, S. J. (1986). Alcohol and other drugs: Facing reality and cynicism. Journal of Counseling and Development, 65(1), 4-5.

Newton, R. M., Elliott, T. A., & Meyer, A. A. (1988). The role of structured work in alcoholism rehabilitation. Journal of Rehabilitation, 54(4), 63-67.

Stude, E. W. (1990). Professionalization of substance abuse counseling. Journal of Applied Rehabilitation Counseling, 21(3), 11-15.

Zavolta, H., & Rogoff, S. (1990). An overview of the vocational rehabilitation process in a long-term drug rehabilitation program. Journal of Applied Rehabilitation Counseling, 21(3), 40-44.

APPENDIX A

Twelve Steps

ORIGINAL TWELVE STEPS

1. We admitted we were powerless over alcohol; that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong, promptly admitted it.

11. Sought through prayer and mediation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result to these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

TBI EXPLANATION SUBMITTED BY WILLIAM PETERMAN

1. Admit that if you drink and/or use drugs your life will be out of control. Admit that the use of substances after having had a traumatic brain injury will make your life unmanageable.

2. You start to believe that someone can help you put your life in order. This someone could be God, an AA group, counselor, sponsor, etc.

3. You decide to get help from others or God. You open yourself up.

4. You will make a complete list of the negative behaviors in your past and current behavior problems. You will also make a list of your positive behaviors.

5. Meet with someone you trust and discuss what you wrote in step 4.

6. Become ready to sincerely try to change your negative behaviors.

7. Ask God for the strength to be a responsible person with responsible behaviors.

8. Make a list of people your negative behaviors have affected. Be ready to apologize or make thing right with them.

9. Contact these people. Apologize or make things right.

10. Continue to check yourself and your behaviors daily. Correct negative behaviors and improve them. If you hurt another person, apologize and make corrections.

11. Stop and think about how you are behaving several times each day. Are my behaviors positive? Am I being responsible? If not, ask for help, Reward yourself when you are able to behave in a positive and responsible fashion.

12. If you try to work these steps you will start to feel much better about yourself. Now it's your turn to help others do the same. Helping others will make you feel even better. Continue to work these steps on a daily basis.

STEPHEN MILLER HOUSE VERSION OF AA 12 STEPS (FOR THE DEAF)

1. We believe that when we drank, alcohol controlled our lives.

2. We began to believe in a Higher Power that would help us think better.

3. We decided to open our lives to God as we understood Him.

4. With courage, we searched our past to see what was good in us and what should be changed.

5. We admitted to God, to ourselves, and to another person all the wrong things we had done.

6. We became ready for God to take away our defects.

7. We honestly asked God to take away our defects.

8. We made a list of all the people we hurt and wanted to make right the wrongs.

9. We tried to make right the wrong things we did but not when it would hurt another person.

10. We continued to search our lives and when we were wrong admitted it at that time.

11. According to the way we understand God, we prayed and meditated to have better contact with Him and asked that He give us strength and guidance.

12. Having a new understanding of ourselves because of the steps, we tried to help others by sharing what we learned and practice these ideas in all daily activities.

APPENDIX B

Drug Street Language

STREET LANGUAGE

The following are terms and phrases used on the street which refer to aspects of substance abuse. The reader is cautioned that such terminology varies from region to region and from one time period to another. Therefore, many such terms may or may not be in current use in the reader's region of the country.

The bulk of this information comes from "Appendix 1 - Street Language" of O'Brien and Cohen (1984) Encyclopedia of Drug Abuse. New York: Facts on File, Inc.

A

Acapulco Gold	An especially potent type of marijuana grown near Acapulco, Mexico
Acid	LSD
Acid Freak	A person exhibiting bizarre behavior after using LSD
Angel Dust, Animal Trank	PCP

B

Bad	A term used for a very good or very potent drug
Bad Trip	A frightening experience while using LSD or marijuana
Bag	A unit of marijuana, heroin, or cocaine for purchase
Barbs	Barbiturates
Bennies	Benzedrine
The Bible	Physicians Desk Reference, PDR
Big Man	The Pusher
Bing	Period of time served in prison
Black Russian	Hashish
Blanco	Spanish term for heroin

Blind Munchies	A strong desire for food (sweets in particular) after smoking marijuana
Blow	Slang for cocaine
Blow-Your-Mind-Roulette	A dangerous party game in which uppers, downers, and other drugs are mixed together and drawn at random and taken. The taker does not know what drug was taken until he/she feels the effects.
Blue Acid	LSD - term comes from the color of LSD when it is seen in large amounts
Blue Angels, Bullets, Devils, Heavens, Tips, Bluebirds, and Blues	All terms for Amytal Sodium
Bong	A water pipe used to smoke marijuana
The Book	PDR
Boost	To shoplift or steal
Boost and Shoot	A person who shoplifts to support a drug habit
Booze Hound	An alcoholic
Brain Ticklers	Amphetamines
Brick	A pressed block of marijuana
Bring Down	To cause someone to lose a high
Brody	To feign sickness in front of a physician in order to obtain prescription drugs
Brown	Heroin, particularly from Mexico
Brown Dots	LSD
Burned Out	Three distinct meanings: (1) drug addicts so weary of the hassles of obtaining illegal drugs that they cease usage; (2) a marijuana smoker usually young, who becomes dull, apathetic and withdraws from usual activities; (3) helping professionals who become discouraged and leave their profession

Bust	A police raid
Button	Peyote
Buzz	Feeling the effect of a drug, particularly marijuana, without unpleasant hallucinations

C

California Sunshine	LSD
Come(Came) Down	To lose the effect of a drug
Candy	Drugs
Candy Man	A drug dealer
Carrying	Having drugs on one's person
Chaser	Something mild to drink after a straight shot of liquor
Chasing The Ghost	Addicted; trying to re-experience the initial high of a drug, particular cocaine or crack
China White	Heroin
Chip	To use drugs on an irregular basis to avoid becoming addicted
Christmas Trees	Dexamyl
Chug-a-Lug	To drink an alcoholic beverage without pausing to breathe between swallows
Clean	Not using drugs or possessing them
Coast	To experience the drowsy effects of heroin
Coke	Cocaine
Coke Head	A user of cocaine

Cold Turkey	Being taken off a drug completely and suddenly without preparation. Quitting a drug without the aid of medication
Come Down	Return to a normal state after the effects of a drug has worn off
Connection	A person's source for purchasing drugs
Cooking	The processing of heating heroin powder with water to render it injectable
Cop	The act of purchasing a drug
Cracking Shorts	Burglarizing cars to support a drug habit
Crank	Amphetamines
Crank Bugs	Hallucination that bugs are crawling under your skin due to an over-use of amphetamines (or cocaine)
Crash	Coming down (falling asleep) after the heavy use of stimulants
Crystal	An injectable form of amphetamines

D

Deal, Dealing	To sell drugs
Dealer	One who sells drugs
Destroying Angels Fly Agaric	
Dexies	Dexedrine
Dirty	Having drugs in one's possession and/or having taken drugs recently
Do, Done, Doing	To take or use drugs
DOA	Phencyclidine (PCP)
Dolls	Amphetamines and Barbiturates (from movie, Valley of the Dolls)
Dry	A person who is against the use or sale of liquor; also abstinence

Dust	Cocaine; angel dust

E

Electric Kool-Aid	A punch mixture containing LSD-25
Eye Opener	The first drink or narcotics shot of the day (for addicts)
Eye Openers	Amphetamines

F

F-40	Seconal
Fiend	A person who uses drugs excessively and uncontrollably
Finger	A condom which contains drugs and is inserted in the rectum, or swallowed
Five Dollar Bag	The same as a five cent paper, packaged in a glassine envelope
Flying	Being high on a drug
Footballs	Dilaudid
Forwards	Amphetamines
Fours	Tylenol with codeine
Freak	A person who prefers a particular drug; also, a hallucinatory or panic reaction to a drug or situation
Frisco Speedball	Heroin, cocaine, and LSD mixed

G

Get Off	To take an injection of heroin; also, to experience the effects of any drug
God's Medicine	Morphine

Gold	Acapulco Gold (marijuana)
Goofball	Barbiturates; amphetamines
Groovy	Feeling high
Gun	Needles used to inject heroin

H

Hang Tough	To withdraw from a drug without "giving in"
Hash	Hashish
Hearts	Amphetamines
Hemp	Marijuana
Hit	To take a drug, especially heroin
Hooked	Addicted
Hop Dog, Hop Head	A person who is addicted to opium
Horse	Heroin
Huffer	A person who inhales drugs

I

Ice Cream Habit	Using drugs occasionally
Indian Hemp	Marijuana
Iron Cure	To withdraw from drugs without any possibility of obtaining them

J

Jammed Up	A person who has overdosed
Jane	Marijuana

Jelly Beans	Amphetamines
Joy Juice	Chloral hydrate
Juanita	Mexican word for marijuana
Juice	Alcohol
Juice Head	A heavy consumer of alcohol
Junk	Drugs, especially heroin
Junkie	A heroin addict

K

Katzenjammers	D.T.'s (delirium tremens)
Kick Cold Turkey	To withdraw from a drug without medication and kick the habit
Kick the Habit	To break a drug addiction
King Kong Pills	Barbiturates
Knockout Drops	A mixture of chloral hydrate and alcohol that causes unconsciousness

L

Lady, Lady Snow	Cocaine
Laughing Gas	Nitrous oxide
Light Stuff	Non-opiate drugs
Line	Abbreviation of mainline (the arterial vein in the arm); or a string of cocaine powder
Love Drug	Quaaludes, MDA
Ludes	Quaaludes

M

Man, The	A high-level drug dealer, or the police
M And C	Morphine (4 parts) and cocaine (1 part)
M And M's	Seconal
Mary Ann, Mary Jane, Mary Warner, Mary Weaver	Marijuana
Merc, Merck, Merk	High-quality drugs (after Merck, Sharp, & Dohme)
Mesc	Mescaline
Meth	Methamphetamine, methedrine
Meth Freak	A heavy user of methedrine
Mickey, Mickey Finn	A mixture of chloral hydrate and alcohol which quickly renders a person unconscious
Microdots	Drops of LSD on blotter paper
M.J.	Marijuana
Monkey, Monkey On My Back	A person's dependence on drugs

N

Nail	Needle used for injection
Narc (Nark)	Any narcotics police officer
Nemish, Nembies	Nembutal
Nickel	Five dollars
Nickel Bag	A $5 bag of drugs
Nose Candy	Cocaine

O

O.D.	Overdose
Off (Getting)	Experiencing the intoxicating effects of drugs
Oil	Hashish oil
On	Means taking a type of drug as in "...on speed"
Orange County Quaaludes	Used since these pills have the number "714" on them. 714 is the area code for Orange County

P

Panama Gold	Red marijuana from Panama
Papers	Folded papers containing drugs (heroin)
Paradise	Cocaine
Peaches	Benzedrine
Peaking	The most intense period during an LSD trip
Pep Pills	Amphetamines
Pinks	Seconal
Pipe	A vein used to inject heroin
Pop, Popping	Taking pills or subcutaneous injection of heroin
Poppers	Amyl nitrite
Pot	Marijuana
Pot Head	A heavy marijuana user
Primo	A high quality drug
Push, Pushing, Pusher	Act of or person who sells drugs

Q

Q's	Quaaludes
Quacks, Quads, Quas	Quaaludes
Quarter	$25.00
Quarter Bag	Twenty-five dollars worth of marijuana
Quill	A rolled up matchbook used to hold a drug while it is sniffed

R

Rap	To talk
Rat	A police informer
Red Birds, Red Devils, Red Dolls, Reds	Seconal
Righteous	A very high quality of drug
Rippers	Amphetamines
Roach	A marijuana cigarette which has burned down too far to be held with the fingers
Roach Clip, Roach Holder, Roach Pick	Any instrument used to hold a roach while smoking it
Rock	A piece of crack cocaine
Rock Star	A woman crack addict who will prostitute herself for crack
Run	An intense heavy period of using a drug such as a "speed run"
Rush	The initial euphenic effect of a drug

S

Scag	Heroin
Score	To buy a drug
Script	A prescription for narcotics
Seven-fourteens (714)	Quaaludes
Shit	Heroin
Shoot-Up	To inject a drug
Short	A car
Skin Shot	Injecting a drug subcutaneously
Sleepers, Sleeping Pills	Barbiturates
Smack	Heroin
Snow	Cocaine
Spaced, Spaced Out	To be under the influence of a mind-altering drug
Speed	Amphetamines, Particularly methedrine
Speed Freak	A heavy user of amphetamines
Sprung	Burned out from cocaine use
Stash	A cache of hidden drugs
Stoned	Being high on a drug
Straighten Out	To prevent the beginnings of withdrawal symptoms by taking more drugs
Strawberry Fields	LSD

Strung, Strung Out	An addict's panic feeling when he is unable to obtain drugs; also, a severe habit, or an addict's physical appearance

T

Tapita	A spanish word for "little cap," referring to the small bottle cap addicts use to cook heroin
Tea	Marijuana, also a term used for psychedelics that are brewed and made into a beverage
Tie	The tourniquet a heroin addict uses to distend a vein when injecting intravenously
Toak, Toke	To smoke a marijuana cigarette. The term refers to both smoking the whole cigarette and just taking a puff.
Tracks	Black and blue needle scars caused by the frequent injection of drugs; also, collapsed veins are referred to as tracks.
Trick	An illegal way of obtaining money for drugs. Probably from the word used by prostitutes for performing sexual favors.
Truck Drivers	Amphetamines
Turnabouts	Amphetamines

U

Upper, Uppies, Ups	Amphetamines
User	A person who uses drugs
Using	Using drugs

V

Vitamin Q	Quaaludes
Voyager	A person who is feeling the effects of LSD

W

Wake Ups	Amphetamines
Wallbangers	Methaqualone. The term is of British origin and is based on abuse of the English drug Mandrax, which contains methaqualone.
Waste	To use, as in "I wasted the marijuana."
Wasted	To lose consciousness from drug intoxication
Weed	Marijuana
White Lightning	LSD; also, a term for un-aged corn whiskey (moonshine)
Wig Out	To "lose you mind (wig)", while using a hallucinogenic drug. A loss of mental control and a state of altered consciousness.
Wired	A person who is feeling the high effects of amphetamines; also, a heroin addict.

Y

Yellow	LSD
Yellow Bullets, Yellow Dolls, Yellow Jackets, Yellows	Nembutal, which is supplied in 30 mg and 100 mg yellow tablets.

Z

Zap, Zapped	To overpower or defeat a person with violence (originally a science fiction term).
Zonked	Acutely intoxicated by a drug

APPENDIX C

Resource Center on Substance Abuse Prevention and Disability

Resource Center on Substance Abuse Prevention and Disability
VSA Educational Services
1331 F Street, N.W., Suite 800
Washington, DC 20004
(202) 783-2900 Voice
(202) 737-0645 TDD
(202) 737-0725 Fax

The Resource Center is an up-to-date source of information about programs, reference materials, and research addressing alcohol and other drug abuse prevention and disability. A person can write, fax, or call, via voice or TDD, for information and referrals. Information specialists are available to answer calls Monday through Friday, 9 a.m. to 5 p.m., EST.

The Resource Center has been developed by VSA Educational Services through a three-year grant from the U.S. Department of Health and Human Services, Office for Substance Abuse Prevention, Division of Communication Programs.

Resource Center on Substance Abuse Prevention and Disability
Suggested Readings

Beck, R., Marr, K., & Tariconi, P. (1991). Identifying and Treating Clients with Physical Disabilities who Have Substance Abuse Problems. ***Rehabilitation Education,*** **Vol. 5, 131-138.**

This article describes the need for rehabilitation counselor training in the area of substance abuse among clients with primary physical disabilities. It describes the lack of well-researched approaches to this problem, presents a model of the state-of-the-art as it is practiced in the field, and recommends areas for further research.

Brown, V. B., & Backer, T. E. (1988). The Substance-Abusing Mentally Ill Patient: Challenges for Professional Education and Training. ***Psychosocial Rehabilitation Journal,*** **Vol. 12, No. 1, 43-54.**

Both mental health and substance abuse professionals need specialized training on how to deal effectively with the dual disordered patient. This article is a report on a multi-part research study which is helping to determine preferred formats and content for such training.

Burns, L. F., & de Miranda, J. (1991). ***Blindness and Visual Impairment: Drug and Alcohol Abuse Prevention and Treatment.*** **San Mateo, CA: Peninsula Health Concepts.**

This report is intended to provide basic information about the relationship between visual impairment/blindness to alcohol and other drug-related problems. It provides a framework for understanding the psychosocial stressors unique to this group of individuals, which may place them at higher risk for maladaptive coping strategies such as alcohol and other drug abuse. This article also presents pertinent information for people wishing to provide services to individuals who are blind or visually impaired.

Cherry, L. (1991). Summary Report. ***Alcohol, Drugs and Disability: National Policy and Leadership Development Symposium.*** **San Mateo, CA: Institute**

This report summarizes the National Policy and Leadership Development Symposium sponsored, in August 1991, by the Institute on Alcohol, Drugs and Disability. It includes information distributed to Symposium participants prior to the event and summaries of the recommendations from seven policy development discussion groups. It also includes suggestions of direct actions that leaders in the movement to gain access to alcohol and other drug services by people with disabilities can take to achieve that goal.

Frieden, A. L. (1990, Fall). Substance Abuse and Disability: The Role of the Independent Living Center. *Journal of Applied Rehabilitation Counseling*, Vol. 21, No. 3, 33-36.

The purpose of this paper is to provide rehabilitation professionals with a general overview of Independent Living Centers and a specific focus on how centers work with clients who have a secondary disability of substance abuse.

Greer, B. C., Roberts, R., & Jenkins, W. M. (1990). Substance Abuse Among Clients with Other Primary Disabilities. *Rehabilitation Education*, Vol. 4, 33-40.

Recent attention in the literature indicates a significantly high incidence of substance abuse among certain types of disabilities, although the prevalence rates vary depending on the study. This article reviews the studies and outlines several factors predisposing individuals with disabilities to the abuse of alcohol and other drugs.

Heinemann, A. W. (1991). Substance Abuse and Spinal Cord Injury. *Paraplegia News*, Vol. 45, No. 7, 16-19.

Studies conducted at the Rehabilitation Institute of Chicago that illuminate the following issues are reported in this article. Substance abuse is a concern for individuals with spinal cord injury in at least three ways: It can be related to the cause of injury; it can impair learning during rehabilitation; it can limit successful outcomes in independent living, employment, and social relationships.

Kircus, E., & Brillhart, B. A. (1990). Dealing with Substance Abuse Among People with Disabilities. *Rehabilitation Nursing*, Vol. 15, No. 5, 250-253.

This article asserts that many people with a physical disability have a hidden disability: substance abuse involving alcohol and/or psychotropic drugs. Patterns of substance abuse behavior vary according to use before disability, following the onset of disability, or both before and following the onset of disability. Substance abuse has a negative impact on a person's vocation, academic performance, family life, and social life, as well as on physical health. Rehabilitation nurses need assessment skills and intervention skills specifically aimed at dealing with substance abuse.

Langley, M. J. (1991). Preventing Post-injury Alcohol-related Problems: A Behavioral Approach. *Work Worth Doing*, pp 251-275. Orlando, FL: Deutsch Press.

This book chapter addresses the widespread recognition of the negative effects of drinking after traumatic brain injury and proposes a behavioral approach which specifically addresses this aspect during rehabilitation. Four stages of treatment are proposed: comprehensive evaluation, motivational enhancement, coping skill training, and structured generalization. In each stage a multidisciplinary approach is adapted and behavioral techniques described.

Miller, B. G. (1989). Empowerment: Treatment Approaches for the Deaf and Chemically Addicted. ***The Counselor,*** **Vol. 7, No. 3, 24-25.**

This article discusses the concerns faced by both professionals and deaf people who are in alcohol and other drug treatment programs and who attend AA/NA meetings.

Miller, C. (1991). Multiple Diagnosis Complicates Drug Abuse Treatment. *NIDA Notes,* **Vol. 6, No. 2, 29-30.**

This is a report on studies being done by a National Institute on Drug Abuse grantee at the University of California in San Francisco. They are studying the growing number of patients who suffer simultaneously from drug addiction, psychiatric disorders, and AIDS.

National Head Injury Foundation, Professional Council, Substance Abuse Task Force. (1989). ***Substance Abuse Task Force White Paper.*** **Washington, DC: National Head Injury Foundation.**

This paper begins to define the extent and nature of the problem of substance abuse in traumatically brain injured individuals. A review of current information regarding substance abuse including research, text, and articles is provided. Techniques currently being utilized in the field of substance abuse and their interrelation with the problems of the head injured individual is discussed as to why they have been found to be inadequate with the traumatically brain injured population.

National Institute on Disability and Rehabilitation Research. (1990). Substance Abuse and Disability. ***Rehab Brief,*** **Vol. 12, No. 12.**

This article was written for the rehabilitation professional, outlining the scope of the problem alcohol and other drug abuse among people with disabilities and why it is often overlooked. It cites studies on the impact alcohol and other drug abuse has on rehabilitation of people with traumatic injuries. The article then discusses the implications for people with psychiatric disabilities or mental retardation. A review of a sample of existing programs is also included.

Pendergast, M., Austin, G., & de Miranda, J. (1990, Summer). Substance Abuse Among Youth with Disabilities. ***Prevention Research Update,*** **No. 7.**

This material provides review of existing research into the issue of alcohol and other drug abuse and disability, including prevalence rates. Abstracts of current research oriented literature are also provided.

Schaschl, S., & Straw, D. (1990, Winter). Chemical Dependency: The Avoided Issue for Physically Disabled Persons. ***AID Bulletin,*** **Vol. 11, No. 2, 1-4.**

This article reviews chemical dependency as a primary health care issue. It provides information on the factors that perpetuate the high rate of chemical dependency for persons with disabilities, including attitudes, myths, enabling, and the interrelationship between disability and chemical dependency. It also reviews a model treatment program and the outcomes.

Shipley, R. W., Taylor, S. M. & Falvo, D. R. (1990). Concurrent Evaluation and Rehabilitation of Trauma and Substance Abuse. ***Journal of Applied Rehabilitation Counseling,*** **Vol. 21, No. 3, 37-39.**

This article addresses the issue that alcohol abuse is closely linked with physical trauma. It also provides the reader with a report on Westmoreland Gateway Alcohol and Drug Rehabilitation Program. This program provides evaluation and rehabilitation services to individuals who are concurrently suffering from physical trauma and alcohol abuse, using specific strategies designed for this population.

Trieschmann, R. (1991, Winter). 23 Reasons to Abuse Drugs and Alcohol and a Few Other Choices Only You can Make. ***Spinal Network EXTRA,*** **36-37.**

Written by a psychologist to a person with a spinal cord injury, this article discusses the problem of alcohol and other drug abuse after injury.

Wade, J. (1990, Feb/March). Can't Just Say No. ***REHAB Management,*** **61-63.**

This article addresses the need for physical therapists to identify and aggressively work with patients who are also substance abusers. References the work of Abbott-Northwestern Hospital-Sister Kenny Institute.

Wenc, F. (1981). The Developmentally Disabled Substance Abuser. ***Alcohol Health and Research World,*** **Vol. 5, No. 2, 42-46.**

An article written for those working in the alcohol and other drug abuse treatment area, it begins with a discussion of the federal legislation that is the cornerstone of the development of policies and services for people who are developmentally disabled. Using services in Wisconsin as an example, it provides information on intervention and other suggested accommodations to the alcohol and other drug treatment service systems.